

# **USAID/Uganda HIV/AIDS Assessment**

Prepared by  
Edward C. Green, BCC Specialist  
Peter McDermott, OVC/MTCT Specialist  
Lillian Mworeko, Care and Support Specialist/PLWHA Involvement  
Sonja Schmidt, M&E Specialist  
Shirl Smith, Multisectoral Specialist/Team Leader  
Paul Waibale, Care and Support/STI Specialist

Submitted to  
USAID Uganda  
January 2003

Submitted by  
The Synergy Project  
TvT Global Health and Development Strategies  
A division of Social and Scientific Systems, Inc.  
1101 Vermont Avenue, N.W. Suite 900  
Washington, DC 20005, USA  
Telephone: (202) 842-2939  
Fax: (202) 842-7646



AID Contact: HRN-C-00-99-00005-00



## ACRONYMS

ABC	Abstain, Be faithful, use Condoms (HIV prevention approach)
ACDI	Agricultural Cooperative Development International
ACET	AIDS Care Education and Training
ACP	AIDS Control Program (Uganda Ministry of Health)
AECF	AIDS Education and Control Project (USAID)
AIC	AIDS Information Centre (an NGO supported by USAID and other donors)
AIDS	acquired immunodeficiency syndrome
AIM	HIV/AIDS Integrated Model District Program
ART	anti-retroviral therapy
ARVs	anti-retrovirals
BCC	behavior change communication
BUCADEF	Buganda Cultural and Development Foundation
CBO	community-based organization
CDC	Centers for Disease Control
CMS	Commercial Market Strategies Project (USAID)
CSO	civil society organization
DANIDA	Danish Agency for Development Assistance
DCOF	Displaced Children and Orphans Fund (USAID)
DfID	Department for International Development (UK)
DHS	demographic and health survey
DISH	Delivery of Improved Services for Health Project (USAID)
DoD	U.S. Department of Defense
EU	European Union
FBO	faith-based organization
HIV	human immunodeficiency virus
IDPs	internally displaced persons
IEC	information, education, and communication
IMAU	Islamic Medical Association of Uganda
ISP	Integrated Strategic Plan (USAID)
KABP	knowledge, attitudes, behaviors, and practices (type of survey study)
KCCC	Kamwokya Christian Caring Community
MAP	Multi-Country HIV/AIDS Program (World Bank)
MOAAIF	Uganda Ministry of Agriculture, Animal Industries and Fisheries
MOES	Uganda Ministry of Education and Sports
MoH	Uganda Ministry of Health
MTCT	mother-to-child transmission
MTEF	Medium Term Expenditure Framework (Government of Uganda)
NACWOLA	National Community for Women Living with HIV/AIDS
NGO	nongovernmental organization
NORAD	Norwegian Agency for Development Cooperation
OI	opportunistic infections
OVC	orphans and vulnerable children
OVCA	orphans and vulnerable children and adolescents
PEAP	Poverty Eradication Action Plan (Government of Uganda)
PHAs	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission

REDSO	Regional Economic Development Services for East and Southern Africa (USAID)
SDU	Strengthening Decentralization in Uganda Project (USAID)
SHEP	School Health Program (Uganda Ministry of Education and Sports)
SO	Strategic Objective
STI	sexually transmitted infection
SWAps	sector-wide approach
TASO	The AIDS Support Organization (an NGO supported by USAID and other donors)
TB	tuberculosis
THETA	Traditional and Modern Practitioners Together Against AIDS
UAC	Uganda AIDS Commission
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASO	Uganda Network of AIDS Service Organizations
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
VCT	Voluntary Counselling and Testing

# TABLE OF CONTENTS

ACRONYMS .....	iii
EXECUTIVE SUMMARY .....	1
Gaps Identified in the Nationwide Response to the HIV/AIDS Epidemic .....	2
The Enabling Environment .....	2
Prevention and Behavior Change Interventions .....	2
Care and Support .....	3
Involvement of Communities, CSOs, and People Living with HIV/AIDS .....	3
Priority Interventions for Strategic Objective 8 .....	3
Proposed Sub-Intermediate Results (sub-IRs) for SO8 in HIV/STI/OI .....	4
I.    Uganda's National Response to HIV/AIDS .....	7
Overview .....	7
Factors Attributed to Uganda's Success .....	8
USAID/Uganda Interventions .....	9
USAID Accomplishments to Date .....	10
Lessons Learned .....	11
Enabling Environment: Multisectoral Response .....	11
Enabling Environment: Donor Involvement .....	12
Prevention: Information, Education, and Communication .....	12
Prevention: Involvement of Traditional Healers and Medicines .....	13
Prevention: Faith-based Contributions .....	14
Care and Support for People with HIV/AIDS: Community Initiatives .....	15
Care and Support for People with HIV/AIDS: Home-based Care .....	15
Care and Support for People with HIV/AIDS: .....	15
Clinical Care and Support .....	15
USAID'S Integrated HIV/AIDS Strategy in Support of Uganda's National Priorities .....	15
II.   Analysis Of Institutional Gaps In Uganda's Response to HIV/AIDS .....	17
The Enabling Environment .....	17
Coordination .....	17
Absorptive Capacity for Expanded Assistance .....	18
Resource Allocation and Mobilization .....	18
Financing HIV/AIDS Prevention and Care Services .....	19
Geographic Coverage .....	20
Surveillance .....	21
Impact of HIV/AIDS on the Social Sector .....	21
Development of a National Policy for HIV/AIDS .....	22
Greater Involvement of People Living with HIV/AIDS .....	22
Prevention and Behavior Change Interventions .....	22
Prevention Programs for Youth .....	22
Voluntary Testing and Counseling .....	23
Prevention and Treatment of Sexually Transmitted Infections .....	23
Prevention of HIV Transmission in the Health Care Setting .....	24
Prevention of Mother-to-Child Transmission .....	24
Care and Support: Mitigating the Impact of HIV/AIDS .....	25
Care and Support of Orphans and Vulnerable Children .....	25
Community Home-Based Care for People with HIV/AIDS .....	25
Treatment Services .....	26
Socioeconomic Mitigation .....	27

Food Assistance.....	27
Income Generation.....	27
III. Priority Interventions for USAID/Uganda’s Strategic Objective 8 .....	29
Prioritization of Objectives .....	29
Proposed Sub-Intermediate Results for SO8 in HIV/STI/OI.....	30
IV. Program Areas to be Addressed by New and Existing Mission Mechanisms under SO8 .....	33
AIDS Information Centre and The AIDS Support organization .....	33
New Scopes of Work for Integrated Services and Systems Strengthening .....	34
Services .....	34
BCC Needs.....	35
Systems .....	36
HIV/AIDS Integrated Model District Program.....	36
Additional Opportunities: The Private Sector.....	37
Illustrative Examples for Integrating HIV/AIDS Activities into New and Existing Mechanisms under SO7, SO8, and SO9.....	37
Example 1 .....	37
Example 2 .....	38
Example 3 .....	38
Example 4 .....	39
Example 5 .....	39
Example 6 .....	39
Example 7 .....	40
Example 8 .....	40
V. CONCLUSION.....	41
APPENDIX A: Statement of Work .....	43
Background.....	43
Purpose of The Contract .....	43
Statement of Work .....	44
Suggested Approach .....	44
Deliverables .....	45
HIV/AIDS Design Team Composition.....	45
Level of Effort.....	46
APPENDIX B: Study Methodology.....	47
Expanded Response .....	47
Youth.....	47
Multisectoral Response.....	47
PHA Involvement .....	47
Behavior Change Communication.....	48
Monitoring .....	48
Clinical Services .....	49
Please List.....	49
Delivery Systems .....	49
Issues.....	49
OVCA .....	49
APPENDIX C: Organizations/Persons Contacted .....	51
REFERENCES AND LITERATURE REVIEWED .....	55

## EXECUTIVE SUMMARY

USAID/Uganda revised its strategic framework in 2001, consolidating its numerous Strategic Objectives (SOs) into three: sustainable opportunities for economic growth, improved human capacity (notably, in education and health), and more effective and participatory governance. In November and December 2001, a Synergy/USAID Assessment team helped USAID/Uganda develop a set of recommendations for integrating HIV/AIDS into the Mission's Strategic Objective 8 (SO8), i.e., human capacity development

The HIV/AIDS Assessment visit was intended to support a broader design exercise carried out by representatives from USAID/Washington and the POPTECH Project. Given the limited time allotted to the assignment—eight days of data gathering in country—the Synergy/USAID Assessment team carried out the following tasks:

- Desk review of Uganda's *National Strategic Framework for HIV/AIDS Activities in Uganda, 2001/2–2005/6* and related current and planned national responses
- Identification of institutional gaps in the nationwide response to the HIV/AIDS epidemic
- Identification of priority sub-results to address HIV/AIDS (and opportunistic infections) to advance USAID/Uganda's SO8 and other strategic objectives, and the Government of Uganda's Poverty Eradication Action Plan
- Identification of gaps to be addressed through USAID/Uganda's new and existing mechanisms (including the AIDS/HIV Integrated Model District Program, Systems contract, Services cooperative agreement, AIDS Information Centre, The AIDS Support Organization, and other SO instruments)
- Identification of illustrative activities to integrate HIV/AIDS issues into mission-wide approaches in all three USAID strategic areas, especially in human capacity development (SO8), but also in improved economic sustainability (SO7), and governance, democracy, and conflict (SO9)

Uganda's remarkable success to date in containing HIV/AIDS owes to a number of critical strategies, including a strong and early response at the national level; extensive contributions from donors, researchers, and numerous nongovernmental organizations (NGOs) and community- and faith-based organizations; decentralized planning and implementation; diverse and extensive Information, Education, Communication/Behavior Change Communication (IEC/BCC) interventions; and condom social marketing, among others.

USAID was one of the first donor agencies to respond to the HIV/AIDS epidemic in Uganda. USAID has been the largest bilateral donor since 1988, contributing more than \$80 million (RFA 617-02-007).

USAID/Uganda's HIV/AIDS portfolio is managed under SO8 and consists of the following core mechanisms: The AIDS Support Organization (TASO), AIDS Information Center (AIC), and HIV/AIDS Integrated Model District Program (AIM). TASO and AIC have received international recognition for their successful work in HIV/AIDS prevention, care, and support. AIC provides voluntary counseling and testing (VCT) in 22 districts, and will be adding 8 districts in the north. TASO works in 8 districts, where it provides care and support to about 18,000 people living with HIV/AIDS. It also operates a training center for counseling, trainers of

trainers, community work, and project management. AIM, a new core program, supports decentralized prevention, and care and support services at district and sub-district levels, as well as strengthens the capacity of NGOs and civil society organizations (CSOs). Other new SO8 core programs focus on improving service delivery of quality services and systems strengthening.

### **Gaps Identified in the Nationwide Response to the HIV/AIDS Epidemic**

To identify gaps in the nationwide response to HIV/AIDS, the Synergy/USAID Assessment team looked at the enabling environment; prevention, care and support; and the involvement of communities, CSOs, and people living with HIV/AIDS.

#### *The Enabling Environment*

Better coordination is needed between government—at the central, district, and community levels—and public-private entities and within the Mission. Clearer reporting responsibilities are needed at the Local Council/LC5 level of district management and service provision. Sustainable focal points should be created at the district level to be responsible for coordination, and stronger political will is needed at district and sub-district levels to address the epidemic. Strengthening public-private collaboration at the district level is also needed. At the central level, the respective roles of the Uganda AIDS Commission (UAC) and the Ministry of Health's AIDS Control Program (ACP) should be further clarified, and collaboration between these organizations, as well as among the non-health ministries in HIV/AIDS activities, should be encouraged. USAID needs to further support and strengthen program coordination at central, district, community, and Mission levels to minimize duplication of effort. USAID's Expanded Response should pace its scaling-up process, increasing the number of CSOs available to work with districts in prevention and care, while ensuring these organizations are effectively positioned geographically and have a critical mass of well-trained staff.

The *National Strategic Framework for HIV/AIDS Activities* spells out useful monitoring and evaluation efforts, but few have been carried out and additional financial assistance is needed to implement them. Better monitoring of behavior changes may also shed light on the impact of prevention messages. The current surveillance system also needs additional trained staff at central and district levels, and improved data management procedures. Independent quality assurance of blood testing is needed to ensure proper HIV diagnosis, and guidelines on prevention of mother-to-child transmission (PMTCT) are needed for antenatal clinic sites.

#### *Prevention and Behavior Change Interventions*

Because Uganda has seen considerable success in decreasing seroprevalence among youth, IEC/BCC approaches may need to focus additional efforts on older cohorts, as through joint VCT of couples. Special emphasis is needed on prevention and behavior change interventions targeted at young girls, who are much more at risk than boys. Critical attention is needed as well for out-of-school youth and to develop youth-friendly social services and clinical facilities, which are now limited. A number of significant gaps are seen in treatment of sexually transmitted infection (STIs.). The issues to be addressed include clients' late reporting for treatment, unsatisfactory health services, inadequately trained staff, and drug stock-outs. The need for scaling up the national program for PMTCT was also identified as a priority, emphasizing the development of a more comprehensive PMTCT package.



### *Care and Support*

To address gaps in psychosocial support of people living with HIV/AIDS (PHAs), cadres of counseling professionals should be defined and trained; the counseling profession is not yet established in public service. Many actions are needed for the education, health, and social development of Uganda's large number of orphans, vulnerable children, and adolescents (OVCA). The ongoing situation analysis is a major step forward toward strengthening coordination and advocacy for OVCA care and support. It will also be critical to define a minimum care and support package for OVCA.

### *Involvement of Communities, CSOs, and People Living with HIV/AIDS*

PHA involvement could be much greater in Uganda, especially at decision-making levels; capacity building and leadership training within higher levels of government and within PHA organizations are needed to ensure this involvement.

### **Priority Interventions for Strategic Objective 8**

The assessment team selected seven (7) priority intervention areas in recognition of USAID/Uganda's relative comparative advantage as a donor to address specific gaps in the nation-wide-response to HIV/AIDS:

- 1) *Strengthened capacities*, especially strengthening public sector capacities at all levels for planning, coordination, quality assurance, resource allocation, resource mobilization, financing, and surveillance, and promoting stronger referral linkages for care and support, treatment, and socioeconomic mitigation among public and private not-for-profit entities. Clear reporting linkages should also be established between the public sector and CSO sectors, to streamline resource utilization and eliminate duplication of effort.
- 2) *Expanded access to and utilization of HIV/AIDS prevention, care, and treatment services*, in particular, minimizing geographic disparities in systems coverage, and strengthening access for displaced and conflict-affected populations. The definition of services includes not only facility-based services, but also services aimed at prevention and community-based socioeconomic mitigation, including food and nutrition support, and income-generation activities.
- 3) *Strengthened community response*, expanding the roles of people with HIV/AIDS, CSOs, traditional healers, faith-based organizations, and the private sector in coordinated, multisectoral responses for prevention, care, and socioeconomic mitigation for PHAs, orphans, vulnerable children and adolescents, and affected families.
- 4) *Improved quality of prevention and care services*, including PMTCT, VCT, and prevention and treatment of STIs, TB, malaria, and other opportunistic infections. Specific needs include the development of a more comprehensive package for PMTCT for mother and family; improved treatment protocols for TB, malaria, and other opportunistic infections (OIs); and stigma reduction among health care practitioners.
- 5) *Second-generation BCC*, with attention to several areas: (a) maintaining and expanding current IEC/BCC activities among 15-19 and 20-24 year olds; (b) the use of second-stage BCC approaches such as life skills training and empowerment interventions for girls and boys, targeted through primary and secondary schools, and to out-of school youth; (c)

BCC for older cohorts, with emphasis on VCT (couples encouraged to be tested and counseled together), faithfulness, and condom use; (d) reducing transmission and increasing the use of risk reduction practices in discordant couples 25-49 years of age; (e) maintaining or increasing preventive activities focused on higher risk populations that are now underserved or under-targeted; and (f) reaching underserved districts with improved peer education and community-based training of trainers, and school-based HIV/AIDS education and life skills training.

- 6) *Strengthened capacity for Monitoring and Evaluation*, through: (a) building capacity to track progress towards goals and objectives under the *National Strategic Framework for HIV/AIDS Activities 2001/2-2005/6* at national and district levels; (b) collecting program-level data and data on national trends in condom use and sexual behavior in keeping with monitoring and reporting requirements for USAID's Expanded Response; (c) using evaluation and behavioral sentinel surveillance (BSS) data to inform programmatic decision making; and (d) using program-level data to improve management and performance.
- 7) *Promotion of social safety networks for orphans and vulnerable children*, for both school attendees and out-of-school youth. These efforts require collaborating with the Ministry of Education and the Ministry of Gender and Social Development to strengthen resource mobilization and education financing options for the payment of school fees, as well as strengthening programmatic links between support and assistance to conflict-affected children and children affected by HIV/AIDS.

### **Proposed Sub-Intermediate Results (sub-IRs) for SO8 in HIV/STI/OI**

*(identified by lower case letters)*

- |           |                                                                                                                                                            |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| IR 8.1.1  | Improved Quality of Social Sector Services                                                                                                                 |
| IR 8.1.1a | Increased availability of HIV/AIDS prevention, care and treatment services that meet national standards in the health, education, and agricultural sectors |
| IR 8.1.1b | Referral systems for STI/HIV/OI treatment services expanded and used                                                                                       |
| IR 8.1.1c | Standards for STI/HIV/OI prevention and treatment services used at facility and non-facility-based service points                                          |
| IR 8.1.2  | Increased Availability and Access to Social Sector Services                                                                                                |
| IR 8.1.2a | Increased coverage of HIV/AIDS services in the health, education, and agriculture sectors                                                                  |
| IR 8.1.2b | Increased utilization of HIV/AIDS services in the health, education, and agriculture sectors                                                               |
| IR 8.1.2c | Programs for orphans and vulnerable children and adolescents expanded in the health and education sectors                                                  |
| IR 8.1.3  | Increased Positive Behavior Changes Adopted                                                                                                                |
| IR 8.1.3a | More girl-friendly and youth-friendly HIV/AIDS prevention programs in place                                                                                |
| IR 8.1.3b | Proportion reporting multiple partners in the past year decreased                                                                                          |
| IR 8.1.3c | Age of sexual debut increased                                                                                                                              |
| IR 8.1.3d | Population aged 15-19 knows two ways to prevent HIV transmission (knowledge of HIV/AIDS) and rejects misconceptions                                        |

IR 8.1.3e	Population aged 20-24 knows two ways of HIV prevention (knowledge of HIV/AIDS) and rejects misconceptions
IR 8.1.3f	Reduction of HIV transmission between regular partners aged 25-49
IR 8.1.3g	BCC, including life skills training, adopted in primary and secondary schools
IR 8.2	Improved Capacity to Sustain Social Sector Services
IR 8.2a	Systems for public sector resource allocation strengthened at national, district, and sub-district levels
IR 8.2b	Increased adoption and monitoring of workplace policies for HIV/AIDS prevention, care, and support
IR 8.2c	Systems for participatory HIV/AIDS planning, resource allocation, and program monitoring used at national, district, and sub-district levels
IR 8.2.1	Improved Decentralized Planning
IR 8.2.1a	Strengthened capacity for HIV/AIDS planning and multisectoral coordination at national, district, and sub-district levels
IR 8.2.1b	Multisectoral HIV/AIDS plans successfully implemented with allocated resources
IR 8.2.2	Increased Private Sector Role in Service Delivery
IR 8.2.2a	Increased private sector role in the delivery of VCT and PMTCT services
IR 8.2.2b	Increased private sector role in the delivery of prevention and support services for orphans and vulnerable children and adolescents
IR 8.3	Strengthened Enabling Environment for Social Sector Services
IR 8.3a	Increased PHA involvement in HIV/STI/OI policy and program formulation at national and district levels
IR 8.3b	National policies developed and implemented for care and support, PMTCT, orphans and vulnerable children, infant feeding, anti-retrovirals, VCT, and HIV/AIDS testing for children.

The role of USAID/Uganda's existing mechanisms under AIC and TASO are critical in pursuing many priorities and should be expanded. AIC program areas should cover second-generation BCC, extending geographic coverage of VCT (together with the SO9 and the Displaced Children and Orphans Fund), capacity building of community service and other organizations to offer more services, and promoting PHA involvement. TASO can provide targeted service delivery entry points and should be involved with the delivery of numerous prevention and care and support services, including grants management and guidelines development. The AIM project is the mechanism under SO8 most effectively positioned to address gaps in district-level coordination of HIV/AIDS interventions in those districts where AIM will be implemented.

Other mechanisms include the new SO8 programs on improving service delivery of quality services and systems strengthening. The HIV/AIDS Basic Package of Services described in the Ministry of Health's Health Sector Strategic Plan for 2000/01–2004/5 identifies services needed at the district level. Resources should also be targeted at strengthening the capacity for HIV/AIDS prevention and impact mitigation in the education sectors. This intervention should especially target life skills training in primary and secondary schools, girls education, and training agricultural extension agents and community-based agricultural and fishery organizations in providing income generation assistance to PHAs and vulnerable families. A

variety of longer-term BCC approaches also would be useful. Key systems and services need to be strengthened at both central and district levels, including quality assurance, information management, and the development of clinical guidelines for HIV/AIDS clinical care and support. The private sector deserves more consideration in developing an integrated strategy for HIV/AIDS prevention and impact mitigation. Workplace programs, for example, can be valuable.

The assessment team also provided illustrative examples for incorporating HIV/AIDS into new and existing mechanisms under USAID/Uganda's SO8, SO7, and SO9.

## I. Uganda's National Response to HIV/AIDS

### Overview

Uganda has experienced the most significant decline in HIV prevalence rates of any country worldwide. National HIV infection rates declined from 21.1% to 6.1% among pregnant women between 1991 and 2000, according to sentinel surveillance at some 14 sites (Government of Uganda, Ministry of Health, 2001). The decline has been most pronounced among younger age cohorts.

Disaggregation of the data by age group for both rural and urban surveillance sites reveals continuing declines in the younger age cohorts 15-19 and 20-24, but the trend of decline seems to be increasingly expressed in the older age group 25-29 as well (Ministry of Health, AIDS Control Program, 2001:6).

Uganda is one of the few countries to also have some incidence data. A cohort of 17,000 people in 5,000 households was followed over an eight-year period (Okware et al., in press). Overall incidence has fallen from 7.6 per thousand per year in 1990 to 3.2 per thousand per year in 1998. As in the case of prevalence, decline is more pronounced among younger age groups.

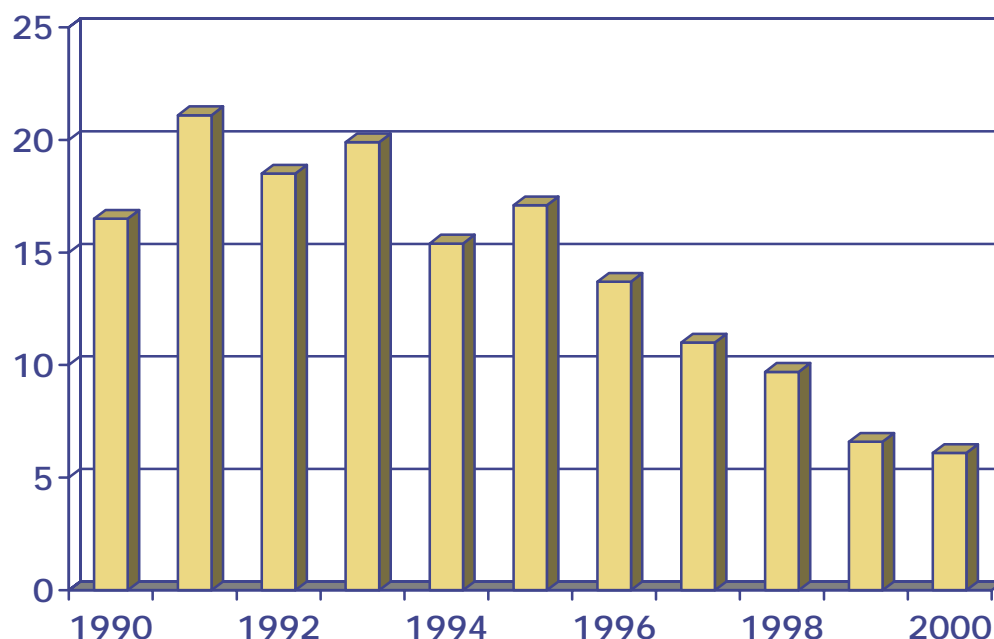
**Table 1. Trends in Incidence, Kyamulibwa, Uganda, 1990-1998**  
(per 1,000 people per year)

	1990	1998
All	7.6	3.2
Male	9.4	2.4
Female	6.0	4.0

SOURCE: Okware et al., in press.

The focus on national trends can obscure the dynamics of local epidemics among different populations who may exhibit different risk factors. There are districts in Uganda where HIV prevalence among the sexually active population reached only relatively low rates. According to the current HIV/AIDS Surveillance Report (Ministry of Health, June 2000), seroprevalence in Moyo district fell from 5.0% to 2.7% between 1993 and 2000; in Pallisa district, from 7.6% to 3.8% between 1992 and 2000; in Soroti, from 9.1% to 5.0%; and in Matany, from 2.8% to 1.9% between 1993 and 2000. Consideration of these data in districts of relatively low seroprevalence weakens the argument that Uganda's HIV seroprevalence decline might have been caused either by the saturation stage of the epidemic or firsthand experience with dying and dead family members, rather than by behavior change or perhaps better treatment of sexually transmitted infections (STIs).

**Figure 1. Uganda HIV seroprevalence trends, 1990–2000**  
(per 1,000 people)



SOURCE: Uganda national sentinel surveillance

Consistent with the decline in HIV prevalence, numerous knowledge, attitudes, behaviors, and practices (KABP) and qualitative studies have indicated positive behavior change. In fact, the greatest degree of behavior change (partner reduction, abstinence/delay, condom use, seeking appropriate STI treatment) has been found among those aged 15-24, the cohort with the greatest decline in HIV infection rates, which therefore may suggest causal linkage between interventions and declining infection rates. Analysis of data on behavior change show there has been more positive change among females than males, and more positive change among urban and better educated than among rural and less-educated Ugandans.

Epidemiological studies undertaken by the Medical Research Council and selected cohort studies from the Rakai Project have also confirmed the decline in HIV seroprevalence and incidence.

### **Factors Attributed to Uganda's Success**

From the prevalence and incidence data, it must be concluded that something special has occurred in Uganda—as compared to many other countries in the world—to explain Uganda's declining HIV rates. Recent analyses by Uganda's Ministry of Health, UNAIDS, ActionAIDS and the World Bank, which discussed the decline of Ugandan HIV infection rates by more than 50%, indicate there is quite good consensus on the presence of the following elements in the successful Ugandan response (Okware et al., in press; Sittirai, 2001; Alwano-Edyegu and Marum, 1999; Kaleeba et al., 2000; Green, 1998):

- An early and strong national response from the highest political level
- A multisectoral response since 1992
- Decentralized planning and implementation since 1995
- A strong and early Information, Education, and Communication(IEC)/Behavior Change Communication (BCC) approach that emphasizes interpersonal, face-to-face, culturally appropriate channels and messages, as well as mass print and electronic media
- IEC/BCC emphasis on targeting youth (youth-friendly approaches) and on empowering women and girls
- IEC/BCC promotion of partner reduction (“fidelity,” “zero-grazing”) and delay of sexual debut
- Condom social marketing
- Respecting and protecting the rights of those infected; roles for people living with AIDS (PHAs) in prevention; combating stigma and discrimination associated with HIV/AIDS
- A strong Voluntary Counseling and Testing (VCT) program
- IEC in the schools (especially primary schools)
- Strong nongovernmental organization (NGO) and community-based organization (CBO) response, leading to flexible and creative interventions and widespread involvement of people at different levels of society (e.g., political leaders at all levels, community leaders, teachers, women and youth leaders, people with HIV/AIDS, and traditional healers)
- Early and significant mobilization of religious leaders and organizations
- Programs to identify and treat sexually transmitted infections (STIs)
- Special programs for high-risk groups (such as commercial sex workers, bar girls, police)
- Good donor support

Adding together all AIDS-related contributions from all sources, total donor support in Uganda between 1989 and 1998 was \$180 million in the past decade, or \$1.80 per adult per year. Donor contributions account for an estimated 70% of total expenditures on AIDS prevention and care in Uganda (Marum and Madraa, 2000). USAID has been the main donor overall, and its AIDS Education and Control Project (AECOP) can be credited with contributing to some of the more innovative elements in the above list, including VCT; counseling and support of PHAs; integrating reproductive health, STI, and HIV services; mass “sensitization” through peer education; AIDS prevention in the military; and mobilization of religious leaders. However, Uganda itself, in both public and private sectors, must be credited with originally developing much of Uganda’s successful model, such as involvement of religious organizations, IEC in primary schools, VCT, and community-based, culturally tailored IEC.

### **USAID/Uganda Interventions**

USAID/Uganda’s program goal is to assist the country in reducing mass poverty. To support this goal more effectively, USAID recently revised its strategic plan to integrate its Strategic Objective 3 (SO3) (basic education) and SO4 (health and population) activities into the new SO8. The focus of this latter strategic objective is to improve human capacity, which is defined as individuals’ ability to reduce their vulnerability to poverty and achieve a better quality of life, by improving their levels of health and education. The HIV/AIDS portfolio is managed through SO8 and consists of the following core mechanisms:

- AIDS Information Centre (AIC) and The AIDS Support Organization (TASO) are two NGOs that have gained international recognition for their contributions to HIV/AIDS control, because of their success in providing HIV/AIDS prevention, care and support, and advocacy in Uganda. Both agencies have received significant contributions from USAID over the past years. AIC provides voluntary counseling and testing in 22 districts and will be adding 8 new districts in the north. TASO works in 8 districts, where it provides care and support to about 18,000 persons living with HIV/AIDS. It also operates a training center for counseling, training of trainers, community work, and project management.
- The HIV/AIDS Integrated Model District Program (AIM), which began in January 2002, is strengthening and supporting HIV/AIDS prevention, and care and support services at district and sub-district levels. The project will support 12 selected districts, to plan, implement, and monitor decentralized HIV/AIDS prevention, care and support activities; and will strengthen the capacity of NGOs and civil society organizations (CSOs) to plan, manage and provide essential services at national, district and sub-district levels.
- Two new SO8 core programs have been developed to address problems related to high is focusing on improving service delivery of quality services, the other on systems strengthening. Both became operational in May 2002.

Other mechanisms under SO7, SO9 and SO8 have incorporated HIV/AIDS activities into their programs. SO8's Commercial Market Strategies (CMS) project, for example, provides social marketing for essential health commodities, including condoms, contraceptives, insecticide-treated bed nets, and an STI treatment, Clear 7. SO7's Title II project aims to provide food assistance to 60,000 people living with HIV/AIDS. SO8's Deliver Project assists the MoH in improving procurement and logistics of essential drugs in the integrated health care package, which includes HIV/AIDS control. USAID collaborates closely with the Centers for Disease Control and Prevention (CDC) in HIV/AIDS surveillance and is the main donor of a situation analysis being conducted on orphans and vulnerable children. This analysis will be used as the foundation for a national policy on orphans and vulnerable children (OVCs) and a strategic plan. USAID provides support to strengthen the Uganda's AIDS Commission's ability to track and monitor HIV/AIDS activities and to evaluate the achievements of the *National Strategic Framework for HIV/AIDS Activities*.

## **USAID Accomplishments to Date**

USAID was one of the first donor agencies to respond to the HIV/AIDS epidemic in Uganda and has been the largest bilateral donor since 1988, contributing more than \$80 million (RFA 617-02-007). The AIDS Education and Control Project (AECPP) was launched in 1991 and was recognized as possibly the most significant intervention in terms of reducing stigma, mobilizing communities, expanding prevention, and consolidating care.

The AIDS Information Centre (AIC), which receives about 80% of its budget from USAID, has tested more than 500,000 people to date, of which 50% are female and 60% between the ages of 15-29 years. The Center has counseling and testing sites in 22 districts but is expanding to an additional 11 districts in the north of the country (RFA 617—2-007). Between 1996 and 2001,



the number of VCT sites increased from 3 to 51 and the number of clients served increased by 67% (USAID/Uganda, Annual Report FY 2002).

Many of the clients served by AIC are referred to The AIDS Support Organization (TASO), which provides prevention and care and support services. TASO receives more than 50% of its budget from USAID (USAID/Uganda PowerPoint presentation). It operates in 8 districts but supports programs in another 21 districts, mainly in capacity building of local NGOs. Since its inception in 1987, it has served almost 70,000 HIV+ patients of which 65% are female and 90% live on marginal income (USAID presentation). Between 1997 and 2001, TASO's client volume increased by more than 160% and the number of counseling sessions increased by almost 170%. (USAID/Uganda, Annual Report FY 2002)

AIC and TASO's contributions, as well as strong political leadership and an open environment, have resulted in a decline of HIV/AIDS prevalence as indicated by the reduction of HIV seroprevalence among women attending antenatal clinics (from 15.4% to 11.8% in urban areas and 8.2% to 4.7% in rural areas). (USAID/Uganda, Annual Report, 2002).

## **Lessons Learned**

A number of important lessons have emerged from Uganda's fight against HIV/AIDS. Political commitment, a broad-based multisectoral response to the epidemic, and an early focus on prevention are among the lessons that can be attributed to Uganda's success in combating the epidemic. Additional lessons can be drawn from the strong and early involvement of the donor community, the intensity and scope of community-led responses in HIV/AIDS care and support, and the prominent role of traditional healers and faith-based organizations in disseminating targeted messages aimed at prevention, increasing awareness, and behavior change.

### *Enabling Environment: Multisectoral Response*

Strong political will at the highest levels of government, combined with a policy of openness, laid the foundation for the achievement of a far-reaching, broad-based multisectoral response by line ministries, faith-based organizations, and community-based NGOs. As explained in the *National Strategic Framework for HIV/AIDS Activities in Uganda, 2001/2-2005/6*, "In 1991, the government adopted a multisectoral approach for the control of HIV/AIDS (MACA) in dealing with the epidemic. This approach emphasized the notion of collective responsibility of individuals, community groups, different levels of government, and other agencies for the prevention of HIV infection" (Government of Uganda, Uganda AIDS Commission et al., 2000).

A critical dimension of Uganda's multisectoral response to HIV/AIDS was the recognition that the effects of HIV/AIDS extended far beyond the health sector. In a measure that demonstrated the government's commitment to the HIV/AIDS issue, the Uganda AIDS Commission was formed in 1992 and placed in the Office of the President (Uganda AIDS Commission, *National Strategic Framework for HIV/AIDS Activities, 2001/2-2005/6*).

### *Enabling Environment: Donor Involvement*

Donor involvement has been critical in Uganda's achievements in HIV/AIDS prevention and impact mitigation. USAID, The World Bank, the UK Department for International Development (DfID), UNICEF, the Danish Agency for Development Assistance (DANIDA), the European Union (EU), the Norwegian Agency for Development Cooperation (NORAD) and others have provided longstanding technical and budgetary assistance to strengthen delivery systems for effective prevention, care, treatment, and clinical services. This support has emphasized strengthening the capacity of NGOs and CBOs, including TASO and AIC.

### *Prevention: Information, Education, and Communication*

Information, education, and communication (IEC) has contributed to positive behavior changes, which themselves are linked to positive results in prevalence and incidence. The focus on IEC has been on youth and on women and girls. Most positive change has been among youth and women. Again, in Uganda, IEC has placed unusual emphasis on "safer sex" (abstinence, delay, partner reduction), compared to that in most other countries, and these are the behaviors that have been seen to change the most.

Uganda's IEC strategy has been to use multiple channels (electronic, print, interpersonal), recognizing that each has advantages and disadvantages, and believing that synergy and maximum exposure can be achieved if all channels are used, especially in complementary and mutually reinforcing ways.

USAID and other donors have financed social marketing and other mass media IEC efforts (e.g., through the Delivery of Improved Services for Health (DISH) Project. In 1999, the Straight Talk Initiative began broadcasting AIDS education and life skills content through seven FM stations. Several local languages are used and the target audience is youth.

A distinguishing feature of Uganda's IEC is the degree to which it is community-based, interpersonal (or face-to-face), and culturally tailored. A great amount of training and sensitization of various community leaders occurred. This seems to have resulted in the sensitization and subsequent involvement in AIDS awareness/education of not only health personnel, traditional healers, and traditional birth attendants, but also of influential people normally not involved in health issues, such as political and religious leaders, teachers, traders, and leaders of women's and youth associations. Methods of training and sensitization often use drama, song, dance, music, poetry, and other indigenous cultural forms of expression. A review of KABP and demographic health survey (DHS) data has found that the main sources of information about HIV/AIDS among Ugandans have been family members and friends, rather than radio or print media (Low-Beer et al., 2000).

*Early Focus on Youth and School.* HIV/AIDS "sensitization" and preventive education have been in the primary school curriculum and syllabus since 1986, through the school health program (SHEP) of the Ministry of Education and Sports (MOES). According to personnel the team spoke with in the MOES, the Ministry of Health (MoH), and the NGO sector (e.g., Straight Talk), there has been a good deal of IEC actually implemented in primary schools. SHEP has

been implemented in public primary schools, but similar NGO-run programs have been used in secondary schools as well.

SHEP teaches the ABCs of HIV/AIDS, often including condom demonstrations. The textbook *Basic Primary Science and Health* (vol. 2) for primary grades 6,7, and 8, produced by the Ministry of Education and the MoH, with UNICEF help in 1987, speaks very clearly about AIDS and even provides a diagram showing explicitly how to put on a condom.

UNICEF's leadership role in establishing the Straight Talk Foundation and strengthening the MOES capacity for school-based education and life skills development were also critical milestones in the establishment of HIV/AIDS sensitization and prevention education programs for school attendees and out-of school youth.

A useful, if perhaps not essential, benefit of involving FBOs early in the epidemic and in significant ways seems to have been that AIDS education, including information on condoms, can usually be taught in schools run by FBOs.

In 1998, a new UNICEF program of "youth friendly services" was piloted in five districts. This minimum package, available in health centers, included IEC, counseling services, recreation, diagnosis and treatment of STIs, and appropriate referrals. Establishment of such services is an objective of USAID's new HIV/AIDS Integrated Model District Program (AIM) project and other planned activities.

If interpersonal IEC has had the impact it seems to have had, then there should be efforts to continue this, as well as mass media IEC. Discussions with those involved in targeting youth in both the public and private sector suggest that there has been a shift in IEC from teaching awareness and the ABCs of HIV/AIDS to teaching skills to young people to empower them to not have sex.

#### *Prevention: Involvement of Traditional Healers and Medicines*

The role of traditional healers in IEC in Uganda has been documented as a UNAIDS Best Practice. The *National Strategic Framework for HIV/AIDS Activities in Uganda, 2001/2-2005/6* affirms the government's continuing relationship with Traditional and Modern Practitioners Together Against AIDS (THETA), and reliance on traditional healers and their local medicines in treatment of PHAs. It mentions the objective of "increasing accessibility to traditional medicines that work" for opportunistic infections. Clinical trials have in fact confirmed the efficacy of locally available herbal medicines for herpes zoster and AIDS-related diarrhea.

THETA has also worked in IEC as well as STI management. Several districts, according to district work plans, have trained traditional healers in recognizing symptoms and referring STI cases as well as in preventive education.

THETA has also done considerable work in sensitization and IEC at the community level. Several hundred traditional healers have been trained directly in IEC, through a rather long training-of-trainers process. This has had a considerable multiplier effect, since a number of districts have either copied this model or developed it themselves, usually training healers in short awareness or Training of Trainer seminars. At least three districts, Moyo, Mbarara and

Mbale, have trained traditional healers in promoting early health care-seeking behavior in clients with likely STIs.

### *Prevention: Faith-based Contributions*

Faith-based organizations (FBOs) are not only the strongest and most influential, but also sometimes the only, nongovernmental organizations in many rural parts of poor countries. FBOs are able to mobilize people and resources and are able to reach rural or isolated areas because of their extensive organizational networks. FBOs tend to have a good understanding of local social and cultural patterns, and larger ones may have strong, expansive infrastructures.

Faith-based organizations and leaders have been strongly involved in AIDS prevention and mitigation since the early years of Uganda's response to the epidemic. This involvement has been seen at all levels, from chairing the Uganda AIDS Committee (two chairpersons, including the incumbent, have been Catholic bishops), to acting at the local community level. FBOs have been involved in care, support, and counseling of PHAs and orphans and vulnerable children, assistance of family members affected by AIDS (including through income-generation initiatives), advocacy, and policy development. The *National Strategic Framework for HIV/AIDS Activities in Uganda, 2001/2-2005/6* lists religious organizations among other NGOs under key involved sectors, for the broad range of activities relating to prevention and mitigation.

FBOs have not only had a significant positive impact on the epidemic (Moodie et al., 1991; Kigimu et al., 1998; Green, 2001), but also in facilitating a relative absence of friction and conflict between public and private AIDS programs and the religious community, as has been found in a number of other countries.

About 60% of all health facilities in Uganda are private, the great majority run by FBOs. According to a 2001 survey, about 44% of private health care is delivered through the Catholic church, 34% Protestant, 8% Muslim, and 14% "other." This fact underscores the importance of the role of FBOs in HIV/AIDS prevention and mitigation. The major FBOs in Uganda, (Catholic, Anglican, Muslim) have been involved in prevention since at least 1990. Beginning in 1992, the USAID-funded AECF project supported and trained these groups further in prevention, with an emphasis on raising awareness and promoting behavior change. Regarding the latter, FBOs have emphasized the behavioral changes that have in subsequent years occurred most frequently, namely partner reduction, delay of sexual debut, and abstinence. The first USAID-supported faith-based initiative in HIV prevention was under AECF.

The main vehicle for preventive work has been training various levels of FBO leaders and peer educators. The groups' efforts have been focused on members of their particular religious group, but these have been expanded in recent years. For example, the Islamic Medical Association of Uganda (IMAU), a UNAIDS best practice, has trained and sensitized non-Muslims and is willing to do more if resources allow (IMAU Interview, 2001).

### *Care and Support for People with HIV/AIDS: Community Initiatives*

Communities have been foremost in bringing about Uganda's success in mobilizing care and support for PHAs. In initiatives in home-based care, support for orphans and vulnerable children (OVCs), and mobilization of FBOs and CSOs, the main response has been at the community level, particularly in the areas of care and support, and HIV prevention through interpersonal communications.

### *Care and Support for People with HIV/AIDS: Home-based Care*

Home-based care has been one of the main innovations and success stories of the Uganda HIV/AIDS program. Home-based care has been responsible for the mobilization of thousands of HIV/AIDS community workers, and it has been a mechanism through which FBO and NGO groups have scaled up their responses. Home-based care is the most important community response, and it has been the entry point for both prevention and care, particularly the care of orphans and children affected by HIV/AIDS. Home-based care has also helped to lower the burden on hospitals for the care of patients with AIDS-related illness.

### *Care and Support for People with HIV/AIDS: Clinical Care and Support*

Opportunities for clinical care and support for people living with AIDS (PHAs) in Uganda have changed dramatically thanks to TASO leadership, the early involvement of faith-based organizations in care and support, and the increased availability of financial resources. Gains made thus far in treating latent TB will help inform the scale-up of INH prophylaxis in the country. Cotrimoxazole (septrin) prophylaxis for PCP and other bacterial and protozoal infections has been found safe and practical at selected TASO sites.

## **USAID'S Integrated HIV/AIDS Strategy in Support of Uganda's National Priorities**

USAID's Integrated HIV/AIDS Strategy is designed to complement the Government of Uganda's broad-range sectoral reform objectives for poverty alleviation and poverty reduction, in addition to supporting the goals and objectives of Uganda's National Strategic Framework for HIV/AIDS activities. The HIV/AIDS agenda ranks high in government and development programs because of the disease's far-reaching socioeconomic and political consequences on society (Okware et al., in press). Within the Government of Uganda's Poverty Eradication Action Plan (PEAP), the following cross-cutting issues have been identified, and have a direct bearing on sectoral outcomes tied to HIV/AIDS prevention and impact mitigation:

- Are the needs of the poorest 20% being met?
- Are gender inequalities addressed?
- Are geographic inequalities addressed?
- Are environmental issues addressed?
- Are there measures to empower the poor (bottom-up accountability)?
- How are intersectoral linkages being addressed?

A stronger enabling environment for sector-wide gains has been established by decentralizing responsibility for AIDS control and prevention to the districts, combined with expanded

partnerships among political, religious, and educational institutions; NGOs; and communities, including people living with HIV/AIDS (Okware et al., in press).

The PEAP also laid the framework to improve resource allocation among the government's sector programs for HIV/AIDS (including Health, Education, and Agriculture), by ensuring that budget allocations for national-level and district-level AIDS prevention and control programs are systematically planned and accounted for in line with the Government of Uganda's Medium Term Expenditure Framework.

Uganda's *National Strategic Framework for HIV/AIDS Activities, 2000/1-2005/6* specifies the following goals:

- Reducing HIV prevalence by 25% by the year 2005/6
- Mitigating the health and socioeconomic effects of HIV/AIDS at individual, household, and community levels
- Strengthening the national capacity to respond to the epidemic
- Systems strengthening, service delivery, and effective resource mobilization remain key elements in improving HIV/AIDS services for Uganda's urban and rural populations
- Issues of equity, affordability, quality, and access also factor into sustainable and measurable reforms across sectors

USAIDs Integrated Strategic Plan for 2002-2007 has been designed to directly support Uganda's focus on poverty alleviation as articulated in the PEAP, and its goals for HIV/AIDS prevalence reduction and impact mitigation as defined in the national strategic framework. In a programming environment driven by the need to build on Uganda's successes in reducing national prevalence and incidence rates, it will be necessary to develop HIV/AIDS interventions that:

- Are appropriate to the current stage of the epidemic
- Build on donor-supported interventions
- Strengthen multisectoral linkages and expanded partnerships among government, faith-based, community-based, and private sector organizations in health, education, agriculture, and commercial sectors
- Assure the appropriate mix of prevention and care necessary to expand coverage and improve the quality of care for a larger segment of the population

## **II. Analysis Of Institutional Gaps In Uganda's Response to HIV/AIDS**

### **The Enabling Environment**

At this stage of Uganda's fight against HIV/AIDS, it will be important for the government to translate the high visibility given to HIV/AIDS at the national level to the district, sub-district, and parish levels. There is a critical need for strengthening the enabling environment for coordination, planning, and resource allocation at national, district, and community level to minimize duplication of effort, and heighten accountability around the use of expanded resources for HIV/AIDS prevention, care and impact mitigation.

### **Coordination**

The success of Uganda's efforts in fighting HIV/AIDS has resulted in a massive increase in international assistance and a significant increase in the number of national and international service organizations operating in the country. These expansions have placed a major burden on the government, the Uganda Aids Commission (UAC), and district authorities in terms of coordination of and accountability for international assistance. In addition, the introduction of new initiatives, strategies, and interventions has demanded greater cohesion, division of labor, effectiveness, and coordination at all levels of HIV/AIDS program implementation in Uganda, specifically at:

- 1) Central
- 2) District
- 3) Community
- 4) USAID Mission

**Central Coordination.** The Uganda AIDS Commission review concluded that national coordination capacity was no longer adapted or sufficient to meet current challenges facing the country. The World Bank HIV/AIDS Control project design/launch documentation also states that coordination requires strengthening. While the main focus of activity in the fight against HIV/AIDS has shifted to district and sub-district levels, there are clear and critical gaps at the central level which, if not addressed, will adversely affect the national response and undermine USAID HIV/AIDS investments and interventions. Given USAID's position as the largest donor, its longstanding experience in supporting HIV/AIDS interventions, and its extensive experience in service delivery at the district level, USAID should actively support and foster coordination.

Of particular importance is the need to clarify the respective roles, responsibilities, and relationships of the UAC and Ministry of Health's AIDS Control program (ACP) and formalize and strengthen collaborative mechanisms. USAID has played a crucial and positive role in overcoming some of the tension that exists between these two entities.

Second, USAID, because of its leadership role in HIV/AIDS, can strengthen the participation and engagement of the non-health ministries in HIV/AIDS activities at the central level, fostering a broader multisectoral response.

***District-Level Coordination.*** The decision to decentralize implementation authority to districts is clearly positive. However, the capacity of districts to coordinate and manage both large numbers of partners and sums of money is unproven. Like the UAC at the central level, districts will require human, financial, technical, and material assistance. Given the increased focus of most organizations to support district-level activities, there is the potential for duplication in both activities and support for the district HIV/AIDS committees. USAID also needs to be aware of the implications of its support under the HIV/AIDS Integrated Model District Program (AIM) project, in particular for the district health management teams, and how this support will relate to functioning of the district HIV committees. Similarly the roles, responsibilities, and relationships of the District Technical Planning Team, the district HIV committee, and district health management team need to be clarified.

***Community-Level Coordination.*** An effective response to HIV/AIDS depends on making interventions community-centered, with full involvement of local communities in strategic planning, implementation, and evaluation processes. Partnerships between the health sector and community-level stakeholders need to be established. (UNASO, 2001)

***USAID Mission Coordination Role.*** Because all of USAID/Uganda's strategic objectives (SOs) are now supporting HIV/AIDS activities, there may be a need to formalize mission-wide coordination mechanisms to ensure that HIV/AIDS activities are complementary and mutually reinforcing. Cases in point are the relationships between HIV/AIDS activities for orphans and vulnerable children and activities of the Displaced Children and Orphans Fund (DCOF) for vulnerable children in the north, education activities related to HIV/AIDS, and Title II food aid, among others. Such coordination mechanisms would also serve the useful purpose of linking USAID Mission efforts with HIV/AIDS activities supported by other U.S. government entities such as CDC, Department of Defense, Peace Corps, and the USAID Regional Economic Development Services for East and Southern Africa Mission in Nairobi, Kenya, among others.

### **Absorptive Capacity for Expanded Assistance**

Uganda has an extremely well developed civil society, with NGOs, CBOs, and faith-based groups all playing extremely important roles in the fight against HIV/AIDS. As these various organizations have evolved and matured, they have been able, with some targeted external support, to significantly expand the scope and geographic reach of their activities. Of particular note has been the focus on empowering communities and support of community-led initiatives. USAID's continued support to strengthen civil society responses to HIV/AIDS is crucial. USAID needs to ensure that financial, material, technical, and human resources are made available to maintain and increase the effectiveness of civil society groups as they expand their response. Strategic planning, project planning, financial management skills, and systems development are all areas requiring additional USAID support.

### **Resource Allocation and Mobilization**

The capacity for resource allocation and mobilization will be critical in achieving sustainable, measurable gains in HIV/AIDS prevention and impact mitigation. Systems involving the transfer of funds from central to district level need to be strengthened to regularize the availability of resources for prevention and care services. The current cash-budgeting system for district funding allocations has led to disruptions not only at the district level, but also at the county,



subcounty, and parish levels. Funding is often retained at the district level once it is received, resulting in further delays at the LC3 and LC1 levels of government.

Two additional problems stem from the lack of resources at the district level to integrate planning functions and to do planning. There is a disconnect between the process initiated through UAC and the World Bank's Multi-country HIV/AIDS Program (MAP) for developing district-level HIV/AIDS plans, and the broader district plans that district and lower levels of government use to allocate resources intersectorally. By way of collaboration with the SO9 Strengthening Decentralization in Uganda (SDU) Project, the Ministry of Local Government, UAC, and World Bank/MAP, it will be in the SO8 team's interest to look at ways of strengthening systems for resource allocation, as it relates to the more systematic channeling, coordination, and use of resources for HIV/AIDS. The use of district HIV/AIDS plans as a mechanism for structuring district-level Sector Wide Approaches (SWAs) tied to Uganda's poverty reduction strategy may also provide opportunities for a more concentrated use of donor funding in line with identified priorities for HIV/AIDS impact mitigation and prevention at district and sub-district levels. District-level systems for financial management, cost accounting, and budgeting should also be strengthened as part of this package, to ensure that districts have a means to track expenditures against performance targets outlined in their district HIV/AIDS plans, intersectoral plans, and the *National Strategic Framework for HIV/AIDS Activities, 2001/2–2005/6*.

### **Financing HIV/AIDS Prevention and Care Services**

In addition to issues of resource allocation, it will be necessary to address gaps relating to the financing of health services. The Ministry of Health includes HIV/AIDS prevention and care services as part of the menu of comprehensive services offered under the Minimum Health Care Package, which has the following aims:

- Attain a 25% percent reduction in HIV seroprevalence
- Increase and sustain male condom use with nonregular partners from 50% to 75% in rural areas and sustain the rate in urban areas at or above the current rate of 80%
- Increase female condom use to about 25% for both urban and rural areas
- Ensure all health units (HC II and above) provide HIV VCT services
- Reduce mother-to-child transmission from 25%-27% to 15%
- Achieve 100% HIV-free blood for transfusion at all levels
- Effectively manage STIs and opportunistic infections in all health units
- Achieve 100% compliance with universal infection control procedures in all health units, public and private
- Provide counseling and psychosocial support to individuals and families affected by HIV
- Promote and participate in research to develop a vaccine and improve prevention and care of HIV/AIDS

While it is a goal that all health units be equipped to provide these services, it is not clear how these services can be covered under the government resource envelope for the health sector strategic plan. Of the total cost estimate for the national HIV/AIDS response, 16% is to come from provisions in the health sector strategic plan, while an estimated 16%-30% is expected to come from other sectors (*National Strategic Framework for HIV/AIDS Activities, 2001/2–2005/6*). The rest of the burden will be addressed by donors. It is still essential for the

Government of Uganda to explore sustainable vehicles for expanding its own internal revenue base for HIV/AIDS services. This could be done by piloting fiscal mechanisms for revenue generation in concert with local governments, or reforming national-level tax structures to expand allocations to HIV/AIDS in the health and other sectors on the frontlines of the nation's response, notably, education, agriculture, water/sanitation, and defense.

A second gap is the lack of affordability and access to HIV/AIDS treatment services among urban and rural populations. Anti-retrovirals (ARVs), for example, are beyond the reach of most Ugandans and are currently not included in the basic package of services provided by all government health units. It may be useful to look to the experience of organizations in the private sector, to see how ARVs are being provided, and to study the costs associated with this service.

A third gap relates to the functioning of employee welfare programs in the government sector. These programs are used by employees to cover expenses for medications, funerals, and other financial obligations. Most funding requests go to mitigating the socioeconomic impacts of HIV/AIDS. The Ministry of Agriculture, Animal Industries and Fisheries (MOAAIF), for example, operates a welfare fund for its employees out of the personnel department. But the fund periodically runs out of money to accommodate client requests (Interview with D. Kasangaki, MOAAIF, December 2001).

### **Geographic Coverage**

There are geographic disparities in access and availability to HIV/AIDS prevention and care services. Service access and availability are relatively poor in several areas:

- Conflict-affected areas
- Districts that are new (recently created as part of Uganda's ongoing decentralization process) and still have a weak service delivery infrastructure
- Districts that are remote or difficult to access.

***HIV/AIDS Services in Conflict-Affected Areas.*** In conflict-affected areas of Uganda, particularly internally displaced persons (IDP) camps, no sentinel surveillance data are being collected. Little is known about the organizations working there. Among the populations living in these regions, there is less openness and willingness to talk about HIV/AIDS. (SO9/DCOF Interviews, December 2001). In Bundibugyo, for example, approximately 60,000–70,000 people are displaced. IDPs in this region of Uganda are subject to idleness, as well as higher risks for HIV/AIDS transmission due to the large number of young women who come in contact with soldiers. There is a breakdown in cultural and family norms; even after a conflict has subsided, there are lasting effects in terms of the fragmentation of traditional family structures. Services in the conflict-affected areas of Kitgum, Pader, and Bundibugyo are also lacking; schools are overcrowded; and the quality of education in IDP camps is lower due to difficult teaching and living conditions. (SO9/DCOF Interviews, December 2001).

***Expanding Access to HIV/AIDS Services in New Districts, and Districts in Remote Locations.*** Attention to alleviating geographic disparities in districts that are new or geographically isolated should be factored into the selection of districts that will receive USAID support. Efforts to improve access to HIV/AIDS prevention and care services might be combined with MOAAIF initiatives and the Agricultural Cooperative Development International/Volunteers in Overseas

Cooperative Assistance/Title II program to increase market access for rural farmers through road construction and expansion of market distribution points.

## **Surveillance**

Data on HIV infection rates are obtained from 20 antenatal sentinel sites located throughout the country and from the STI patients attending one major hospital in Kampala. Blood samples are collected every quarter and tested at the Uganda Virus Research Institute. The testing is done anonymously. (HIV/AIDS Surveillance Report, STI/AIDS Control Programme, MoH, June 2001). A sentinel surveillance system that relies on antenatal clinics may underestimate the true prevalence of the disease among women because it excludes other risk groups like women who are not pregnant. Moreover, all antenatal sentinel sites in Uganda are in urban or peri-urban localities, where HIV infection rates are higher than in rural areas (where 90% of the population lives). (HIV/AIDS Surveillance Report, STI/AIDS Control Programme, MoH, June 2001). The HIV prevalence rates collected from these ANC sites may therefore also tend to overestimate HIV infection in both males and females.

There are also gaps in behavioral surveillance. The behavioral surveillance team in the National Surveillance Unit needs to be equipped to look at more complex relationships, and to isolate where incidence is occurring in line with the stage and progression of the epidemic in Uganda. In the context of strengthening systems for behavioral surveillance, it will be especially important to look at older age cohorts, and define new indicators, which address complex risk behaviors for this age group. (CDC Interview, November 2001). A stronger behavioral surveillance system will be instrumental to informing the selection of prevention, care, and treatment interventions for a population that has already lived through the first wave of the epidemic (CDC Interview, November 2001).

## **Impact of HIV/AIDS on the Social Sector**

A fundamental element of the proposed Uganda strategy is to increase access to and demand for quality education and health services as close to the community as possible. While access to education and health services has increased, in part because of the abolition of user fees, major geographic and vulnerable population disparities still exist. In addition, as access and utilization have increased, serious concerns have been raised about quality.

This situation has been exacerbated by the problems that the epidemic has raised for the systems, structures, and human resource capacity of the education and health ministries themselves. It would seem that Uganda is no different from other countries in the region in that recent gains in educational achievement and reduced infant and child mortality are being rapidly eroded. (P. McDermott, December 2001). Further, the impacts on health and education systems and human resources have been significantly underestimated. It appears (though has not been validated) that the impact on education and health staff in Uganda is higher than on many other segments of the population, including same-age cohorts. The effects of the epidemic on the functioning of education and health sectors need to be more rigorously analyzed. Of particular concern are staff losses, absenteeism, replacement requirements, and costs. The government is increasingly challenged to provide existing levels of services, and can hardly cope with the increased demands created by the abolition of user fees and by the pandemic itself. (P. McDermott, December 2001).

## **Development of a National Policy for HIV/AIDS**

The national HIV/AIDS policy is still in a draft form. Issues of VCT, PMTCT, and the rights and responsibilities of people living with AIDS need to be more directly addressed in order to sustain the achievements that Uganda has made in reducing seroprevalence. Standards and treatment protocols for the care of people living with AIDS will need to be developed based on a fundamental respect for human rights, as well as a platform of ethics, confidentiality, informed consent, privacy, and individual dignity. (Personal Observation, L. Mworeko, December 2001).

## **Greater Involvement of People Living with HIV/AIDS**

The involvement of people living with AIDS (PHAs) could be much greater in Uganda, especially at decision-making levels. Of those PHAs who are open about their status, few are in key positions to effect change. Further, it is only recently that the UAC has included a PHA as a commissioner on the board. In many local AIDS organizations, involvement of PHAs has been limited to awareness-raising campaigns, delivery of testimonies, and the like, but few PHAs have been assigned to top management positions. (Personal Observation, L. Mworeko, December 2001).

More capacity building and leadership training is needed to bolster the number of PHAs positioned in higher levels of government, and the numbers who can affect policy dialogue through existing PHA networks. Valuable activities would include skill building for PHA organizations in marketing and member outreach to widen the membership base, and to ensure that such organizations are responsive to needs and interests of PHAs, enhancing their quality of life and sense of belonging in the community.

## **Prevention and Behavior Change Interventions**

### *Prevention Programs for Youth*

Young people (ages 15-29) are among those most vulnerable to HIV infection. Girls in this age group are 4 to 6 times more likely to be infected than boys (Uganda AIDS Commission/National AIDS Documentation Center. The “Sugar Daddy” complex is still a risk behavior that needs to be addressed in targeting behavior change and prevention messages for girls living in urban and rural settings. Empowerment of girls in abstinence, condom use, and negotiation of safer sex requires further programmatic expansion in the provision of life skills training in schools and through peer education. (Personal Observation, L. Mworeko, December 2001)

More IEC and behavior change interventions aimed at out-of-school youth are needed to reduce the risk of HIV transmission in the 15-29-year-old age bracket. Annual festivals, get-togethers, and Straight Talk shows have been effective in reaching school attendees, but less so in reaching out-of-school-youth who are often more vulnerable. Adolescent-friendly social centers and clinical facilities are critically needed, where young people can access treatment for STIs and receive VCT counseling in a confidential setting. (Personal Observation, L. Mworeko, December 2001).

In identifying steps to minimize risk behaviors and promote behavior change among youth, several questions should be kept in mind: What kinds of interventions will be effective in helping

young people transform knowledge into action? What forums should be targeted? How can information best be presented, and to what groups of people?

### ***Voluntary Testing and Counseling***

Despite the good VCT system in Uganda, there are still major gaps in the provision of these services. Approximately 50% of districts are not yet covered by any VCT service. Government and development partners must strengthen the coordinating mechanisms to ensure that there is countrywide and rural coverage. Since cost sharing was eliminated in government institutions, VCT outreach services cannot be provided because of lack of funds. The Government of Uganda is covering this cost at some of the public VCT sites, but the systematic delivery of VCT outreach services needs to be further streamlined and included in all district plans.

The social marketing of VCT couples testing has also been scaled back, despite the documented effectiveness of this intervention in reducing the risk of transmission in discordant and non-discordant couples. (CDC Interview, November 2001).

### ***Prevention and Treatment of Sexually Transmitted Infections***

The biggest challenge for the prevention and treatment of STIs in Uganda is clients' late reporting for treatment. This delay is most likely due to myths and misconceptions about STIs and/or poor mobilization of communities (STD/AIDS Control Programme, Ministry of Health, 1999). STI services offered at health facilities are often unsatisfactory, particularly at peripheral health units where health workers may be inadequately trained. The Ministry of Health integrated supervision teams commonly report stock-out for STI drugs at health units throughout the country

Several drugs are required in combination when using the syndromic approach to management of STIs. Component drugs in the combination may sometimes not be available due to poor distribution mechanisms or the drug's use for other purposes. For example, ciprofloxacin, a drug used in combination with others to treat the male discharge syndrome, is usually diverted and used for respiratory infections. Component drugs for a syndrome must be procured, distributed, and dispensed as a package to strengthen the syndromic management of STIs. (P. Waibale, December 2001).

Despite the Government of Uganda's stipulating minimum staffing levels for health units, local governments have not succeeded in filling all the available posts. Several health units are still headed by non-professional staff who usually find it difficult to comprehend the syndromic management of STIs (personal communication, Dr. Fred Kambugu, Head, STD Unit, Mulago Hospital). This circumstance has necessitated continued training to improve staff capacity.

Even with the proper training of health workers and provision of the necessary drugs and supplies, quality assurance of STI care services remains a big challenge to the health care delivery system. The number of clients seeking care for STIs continues to rise and certainly stretches the available resources and compromises quality. The elimination of cost sharing in government institutions may have also adversely affected STI care because some additional drugs were purchased from this fund. (P. Waibale, December 2001)

STI care in private for-profit institutions does not in most instances follow the syndromic approach. The etiological approach these institutions use requires laboratory guidance and often misses the mixed infections that are common in the population (P. Waibale, 2001). Quality of care in this sector remains a challenge for the government, which must establish partnerships to create a common position of action.

Given the association between HIV and STIs, the gaps identified above need to be addressed as priority measures in preventing transmission of HIV.

### ***Prevention of HIV Transmission in the Health Care Setting***

Infection control in the health care setting and in the home requires supplies like protective wear, detergents and disinfectants, linens, and sundries. Well-trained and committed health staff are essential in utilizing the supplies correctly. Currently, 50% of health units have established infection control committees whose responsibility is to plan and implement an infection control system in the unit. Unfortunately, over time these committees have lost their prominence and serve residual roles only. Consequently, the functions of quality assurance for infection control standards have been relegated to the traditional supervisory system. Supplies, sundries, and detergents are most times inadequate at points of use and their absence severely de-motivates health workers. Facilities for disposal of medical waste are quite poor in the majority of health units. (Waibale, P., December 2001).

The Government of Uganda continues to address some of these gaps, but the financial resources required to do so are enormous. Because infection control is a critical component of care in the health unit and the home, USAID may have to consider supporting specific components of the infection control system.

### ***Prevention of Mother-to-Child Transmission***

The Ministry of Health in Uganda cited limitations in geographic coverage as the primary gap in the delivery of mother-to-child transmission (MTCT) services on a national level. (Interview with S. Onyango, MoH, 2001). Currently, PMTCT is only available at the following hospital centers: Mulago, Mengo, Nsambya, Arua, Lacor, Hoima, Mbala, Mbarara, and Iganga.

There is also a challenge of integrating the prevention of MTCT (PMTCT) into existing maternal and child health services, given limited infrastructure, and gaps in human resources due to attrition and low replacement rates (Interview with S. Onyango, MoH, 2001). PMTCT as an entry point for reproductive health programs also requires a catalytic start, including the linking of PMTCT with STI and VCT services (Interview with M. Mugabe, UNICEF, December 2001). Bringing the "M" more to the forefront also needs to be an integral component of a national PMTCT strategy, through the provision of ARVs, treatment of OIs, and more supportive counseling for mothers. (Interview with M. Mugabe, UNICEF, December 2001).

## **Care and Support: Mitigating the Impact of HIV/AIDS**

Continued investments in prevention need to be complemented by targeted measures to strengthen to strengthen the existing infrastructure for care and support in Uganda. The scaling-up of interventions for orphans, vulnerable children and adolescents (OVCAs), community home-based care, and clinical care services are critical elements for expanding access to care and support, and improving the quality of life of populations infected or affected by HIV and AIDS.

### ***Care and Support of Orphans and Vulnerable Children***

It is clear from many studies that large numbers of orphaned and vulnerable children (OVCs) in Uganda present a major concern for education, for health and social development. In defining interventions for orphans and vulnerable children, an explicit strategy should be articulated. Possible parameters are geographic, according to prevalence and number of OVCs, poverty index distribution, community identification methods, or some form of self-targeting such as pilot districts. There is ongoing debate about targeting as to who is most at risk, whether double orphans, child-headed households, single orphans, children living in households with sick and dying parents, orphans on the street and in institutions, and/or children in extremely poor households. Much of the debate is academic. Nonetheless, with limited funds available, choices do need to be made. Capacitating the communities themselves to identify child vulnerability seems to be the most equitable and socially acceptable methodology in addressing this dilemma. (P. McDermott, December 2001).

Additional gaps include the need for expanded social safety nets for orphans, vulnerable children, and adolescents (OVCAs), including life skills training for in-school and out-of-school youth, nutritional and income generation support, and the establishment of youth-friendly health services. USAID's planned study on OVCAs will be key to informing the development of a national policy and strategic framework on orphans and vulnerable children, which the Government of Uganda is currently lacking. (Interview with M. Mugabe, UNICEF, December 2001). UNICEF's Adolescent Program, which provides support for government and civil society to put programs in place for adolescent friendly health services, VCT services, and educational support, bears important implications for the scaling-up of interventions aimed at OVCAs, and for the establishment of a government model for keeping children from vulnerability. (Interview with M. Mugabe, UNICEF, December 2001).

### ***Community Home-Based Care for People with HIV/AIDS***

Numerous gaps have been identified in the delivery of home-based care services in Uganda. Home caregivers—volunteers, family members, friends, relatives, and communities—lack basic nursing skills. Often they are reluctant to handle patients for fear of contracting the virus. Provision of tool kits to families for the prevention of transmission (gloves, cotton wool, bed sheets, scouring powder, etc.) on a larger scale would greatly improve the quality of service given by home-based caregivers. (Personal Observation, L. Mworeko, December 2001). More counseling is also needed to support home care providers, in addition to establishing systems for peer support and psychosocial support for families. (Personal Observation, L. Mworeko, December 2001).

## *Treatment Services*

*Tuberculosis and other Opportunistic Infections.* Screening for TB and active case detection requires intensifying. Protocols for active TB treatment also need to be strengthened. There is also a need to link HIV counseling and testing services with TB clinics throughout the country. Approximately 5% of patients screened at TB clinics have active TB, but are not tested for HIV. (Interview with CDC, December 2001). The capacity for TB counseling at AIDS Information Centre (AIC) also needs to be expanded. (Interview with CDC, December 2001). There is an 80% completion rate for INH prophylaxis at AIC centers, and a 46% loss rate before people enter the program. (Interview with CDC, December 2001).

Management of other OIs in children and adults requires strengthening, particularly at public institutions, in the following areas: attitude change among health workers; addressing knowledge and skills gaps; harmonizing training curricula for managing HIV/AIDS in adults and children; support for drug quantification, procurement, and distribution; inclusion of more expensive drugs like fluconazole and acyclovir on the drug list and establishing mechanisms with UNAIDS and other partners to negotiate for price reductions; and promoting private-public partnerships. (Interview with CDC, December 2001).

*Access to Anti-Retroviral Drugs.* Many private treatment facilities now provide ARVs, and the number of Ugandans accessing them has increased substantially. However, current prices are still too high for most Ugandans who require these drugs. Use is therefore limited to those with the ability to pay. (Interview, Mildmay Training Center, December 2001). Moreover, effective delivery systems for ARVs are lacking, including adequate networks of health care facilities staffed by trained personnel, adequate communications among far-flung health facilities, and maintenance of a constant supply of several drugs. These problems, along with the complexities of teaching correct usage and complex drug-taking regimens, often result in irregular compliance, which must be addressed in determining a nationwide strategy for increasing coverage and expanding access to ARVs. (Interview with CDC, December 2001)

*Palliative Care.* Hospice and Mildmay Uganda are the major providers and advocates for palliative care in Uganda. TASO also has staff among its ranks that are trained in the delivery of palliative care, but the availability and range of palliative care services is still quite limited on a national scale. (Interviews, Mildmay Center and TASO, December 2001). Gaps relating to the delivery and scaling up of palliative care services include the following:

- There are differences in understanding of palliative care: some organizations view it as the whole range of care services offered to PHAs from time of HIV diagnosis until death, while other organizations limit palliative care to the management of pain in the terminal stages of illness.
- Stronger advocacy is needed to promote the inclusion of palliative care into the district plans at the national and district levels. This will help ensure that the resources necessary for its implementation are made available.
- Few health workers are equipped with adequate knowledge and skills to provide palliative care. Where they exist, such cadres are usually constrained by lack of supplies and drugs required for service delivery.



## Socioeconomic Mitigation

**Food Assistance.** In line with the need to increase coverage and access to care and support services, it will be essential to strengthen multisectoral linkages and systems for coordination among civil society organizations, agricultural providers, and the public sector to ensure the sustainable distribution of foodstuffs and food supplies to PHAs and affected households. While food assistance is offered by a number of CSOs in Uganda, it will still be critical for the CSOs that provide clinical care and psychosocial support services to look at ways of ensuring that PHAs and affected families are linked to food assistance programs as part of a comprehensive menu of services.

While the Title II program will be effective in strengthening the capacity of large civil society organizations to mobilize food assistance to large segments of Uganda's rural population, a gap still exists in the structuring of tangible partnerships with the Ministry of Agriculture. The types of organizations eligible to participate in the Title II program are restricted, and so interventions have effectively by-passed a number of relevant entities: the ministries of Agriculture, Education, and Gender and Social Development, along with other public sector entities with mandates to provide food assistance to vulnerable groups, including PHAs, orphans and vulnerable adolescents, and youth. The MOAAIF, through its national-level Agricultural Sector Plan for HIV/AIDS, and through the involvement of district-level agricultural production officers in district multisectoral HIV/AIDS planning, is in a leadership position to promote stronger coordination among the public sector, NGOs, and the private sector to provide nutritional support and food assistance to affected families. MOAAIF views the Title II program as duplicative, given that the ministry itself needs a stronger capacity to manage bottlenecks resulting from seasonal oversupplies of agricultural produce, limited market access, and an inadequate reserve system. (Interview with D. Kasangaki, MOAAIF, December 2001)

**Income Generation.** The AIDS Support Organization (TASO), National Community for Women Living with AIDS (NACOWLA), and other community-based organizations provide vocational training for client members, but they have no strong linkages/referral relationships with microenterprise projects or agricultural organizations to create a wide range of sustainable options for income generation or income diversification for PHAs and affected families. TASO's Mulago Center, for example, provides vocational support for children through skills training in carpentry, hairdressing, tailoring, and handicrafts production. This center does not, however, have direct referral linkages to help with job placement or involvement in community-based microenterprise schemes. At its headquarters, TASO is now in the process of establishing day centers for job training and income generation as part of the organization's minimum package of services.

In the *National Strategic Framework for HIV/AIDS Activities in Uganda 2000/1–2005/6*, the Uganda AIDS Commission cites the need for expanded economic assistance to PHA families. To accomplish this strategy, better referral systems must be created among organizations that provide counseling, medical care, social support services, and community-based income generation projects offering skills training and employment for PHAs. Through sensitization and awareness raising, the private sector should also be tapped to widen the range of employment options for PHAs, with particular emphasis on adolescent and college-age youth.

Because most of Uganda's population is rural, measurable gains might also be made through the provision of income assistance to families engaged in small-scale agricultural production. The Title II program will also be providing PHAs and affected families with technology assistance so that family income levels can be effectively maintained if one or more income-earners become incapacitated or unable to work. Technologies for plant-spacing, use of improved seed varieties, and post-harvest handling are among the innovations that will be used to strengthen the earning power of affected households. (Interview with Agricultural Cooperative Development International, December 2001). More of these interventions should be specifically directed to assist child-headed and woman-headed households, and to help clients achieve a more regular income base for school fees, medications, and other basic needs.

### III. Priority Interventions for USAID/Uganda's Strategic Objective 8

#### Prioritization of Objectives

The HIV/AIDS Assessment team selected seven (7) priority intervention areas in recognition of USAID/Uganda's relative comparative advantage as a donor to address specific gaps in the nation-wide-response to HIV/AIDS. These priority intervention areas were identified on the basis of the following criteria: 1) USAID/Uganda's strategic and manageable interest, and 2) Mission goals for expanding coverage and access to HIV/AIDS prevention and treatment services.

The following priority intervention areas seek to mitigate existing nation-wide gaps in the management and coordination of HIV/AIDS services at national, district, and sub-district levels, HIV/AIDS prevention, care and support, and impact mitigation. These intervention areas are recommended as the essential core components of a comprehensive framework for integrating HIV/AIDS issues into the USAID/Mission's strategy for SO8:

- 1) *Strengthened capacities*, especially systems strengthening at central, district, and sub-district levels. A primary focus of this intervention area is to strengthen public sector capacities for coordination, quality assurance, resource allocation, resource mobilization, financing, and surveillance, and promote stronger referral linkages for care and support, treatment, and socioeconomic mitigation between the public sector and the private not-for-profit sector. Another need is to establish clear reporting relationships between the public and not-for-profit sectors, to streamline resource utilization and eliminate duplication of effort.
- 2) *Expanded access to and utilization of HIV/AIDS prevention, care, and treatment services*, in particular, minimizing geographic disparities in systems coverage, and strengthening access for displaced and conflict-affected populations. The definition of services includes not only facility-based services, but also services aimed at prevention and community-based socioeconomic mitigation, including food and nutrition support, and income-generation activities.
- 3) *Strengthened community response*, expanding the roles of people with HIV/AIDS, civil society organizations, traditional healers, faith-based organizations, and the private sector in supporting coordinated, multisectoral responses for prevention, care, and socioeconomic mitigation for PHAs, orphans, and vulnerable children and adolescents, and affected families.
- 4) *Improved quality of prevention and care services*, including prevention of mother-to-child transmission, voluntary testing and counseling, and prevention and treatment of STIs, TB, malaria, and other opportunistic infections. Specific needs include the development of a more comprehensive package for PMTCT that focuses on the mother and the family; improved treatment protocols for TB, malaria, and other OIs; and stigma reduction for health care practitioners.

- 5) *Second-generation BCC*, with attention to several areas: (a) maintaining and expanding current IEC/BCC activities among 15-19 and 20-24 year olds; (b) the use of such second-stage BCC approaches as life skills training, and empowerment interventions for girls and boys, targeted through primary and secondary schools, and to out-of school youth; (c) BCC for older cohorts, with emphasis on VCT (couples being tested and counseled together), faithfulness, and condom use; (d) reducing transmission and increasing the use of risk reduction practices in discordant couples 25-49 years of age; (e) maintaining or increasing preventive activities focused on higher risk populations that are now underserved or under-targeted; and (f) reaching underserved districts with improved peer education and community-based training of trainers, and school-based HIV/AIDS education and life skills training.
- 6) *Strengthened capacity for M&E*, through (a) building capacity to track progress towards goals and objectives under the *National Strategic Framework for HIV/AIDS Activities 2001/2-2005/6* at national and district levels; (b) collecting program-level data and data on national trends in condom use and sexual behavior in keeping with monitoring and reporting requirements for USAID's Expanded Response; (c) using evaluation and behavioral sentinel surveillance (BSS) data to inform programmatic decision making; and (d) using program-level data to improve management and performance.
- 7) *Promotion of social safety networks for orphans and vulnerable children*, for both school attendees and out-of-school youth. These efforts require collaborating with the Ministry of Education and the Ministry of Gender and Social Development to strengthen resource mobilization and education financing options for the payment of school fees, as well as strengthening programmatic links between support and assistance to conflict-affected children and children affected by HIV/AIDS.

### **Proposed Sub-Intermediate Results for SO8 in HIV/STI/OI**

For USAID's integrated strategy and results framework for SO8, the following additional sub-IRs (Intermediate Results) are proposed (proposed sub-IRs are identified by lower-case letters):

- |           |                                                                                                                                                            |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| IR 8.1.1  | Improved Quality of Social Sector Services                                                                                                                 |
| IR 8.1.1a | Increased availability of HIV/AIDS prevention, care and treatment services that meet national standards in the health, education, and agricultural sectors |
| IR 8.1.1b | Referral systems for STI/HIV/OI treatment services expanded and used                                                                                       |
| IR 8.1.1c | Standards for STI/HIV/OI prevention and treatment services used at facility and non-facility-based service points                                          |
| IR 8.1.2  | Increased Availability and Access to Social Sector Services                                                                                                |
| IR 8.1.2a | Increased coverage of HIV/AIDS services in the health, education, and agriculture sectors                                                                  |
| IR 8.1.2b | Increased utilization of HIV/AIDS services in the health, education, and agriculture sectors                                                               |
| IR 8.1.2c | Programs for orphans and vulnerable children and adolescents expanded in the health and education sectors                                                  |

IR 8.1.3	Increased Positive Behavior Changes Adopted
IR 8.1.3a	More girl-friendly and youth-friendly HIV/AIDS prevention programs in place
IR 8.1.3b	Proportion reporting multiple partners in the past year decreased
IR 8.1.3c	Age of sexual debut increased
IR 8.1.3d	Population aged 15-19 knows two ways to prevent HIV transmission (knowledge of HIV/AIDS) and rejects misconceptions
IR 8.1.3e	Population aged 20-24 knows two ways of HIV prevention (knowledge of HIV/AIDS) and rejects misconceptions
IR 8.1.3f	Reduction of HIV transmission between regular partners aged 25-49
IR 8.1.3g	BCC, including life skills training, adopted in primary and secondary schools
IR 8.2	Improved Capacity to Sustain Social Sector Services
IR 8.2a	Systems for public sector resource allocation strengthened at national, district, and sub-district levels
IR 8.2b	Increased adoption and monitoring of workplace policies for HIV/AIDS prevention, care, and support
IR 8.2c	Systems for participatory HIV/AIDS planning, resource allocation, and program monitoring used at national, district, and sub-district levels
IR 8.2.1	Improved Decentralized Planning
IR 8.2.1a	Strengthened capacity for HIV/AIDS planning and multisectoral coordination at national, district, and sub-district levels
IR 8.2.1b	Multisectoral HIV/AIDS plans successfully implemented with allocated resources
IR 8.2.2	Increased Private Sector Role in Service Delivery
IR 8.2.2a	Increased private sector role in the delivery of VCT and PMTCT services
IR 8.2.2b	Increased private sector role in the delivery of prevention and support services for orphans and vulnerable children and adolescents
IR 8.3	Strengthened Enabling Environment for Social Sector Services
IR 8.3a	Increased PHA involvement in HIV/STI/OI policy and program formulation at national and district levels
IR 8.3b	National policies developed and implemented for care and support, PMTCT, orphans and vulnerable children, infant feeding, anti-retrovirals, VCT, and HIV/AIDS testing for children.



## **IV. Program Areas to be Addressed by New and Existing Mission Mechanisms under SO8**

### **AIDS Information Centre and The AIDS Support organization**

USAID/Uganda's support of AIDS Information Centre (AIC) and The AIDS Support Organization (TASO) has been instrumental in achieving measurable gains in combating the HIV/AIDS epidemic. The roles of these two pivotal civil society organizations should be expanded to address many of the gaps in the current nationwide response to the epidemic.

In shaping an integrated strategy that links HIV/AIDS prevention and impact mitigation to the strengthening of social sector service delivery and systems performance in Uganda, continued support to AIC and TASO will be essential for several Mission priorities:

- Achieving rapid scale-up
- Minimizing geographic disparities in coverage, access, and quality of HIV/AIDS prevention, care, and treatment services
- Expanding service entry points for youth by way of stronger referral networks and creation of adolescent-friendly services
- Strengthening public-private partnerships
- Launching second-generation BCC and prevention activities for youth and older-age cohorts
- Sustaining community-level gains in delivering comprehensive support services
- Improving multisectoral coordination
- Assisting government in setting standards for VCT, and care and support
- Improving coordination between CSOs and private and public sectors to achieve the goals and strategies of the *National Strategic Framework for HIV/AIDS Activities*

### *AIDS Information Centre*

Under USAID/Uganda's integrated strategy for SO8, the following program areas are proposed for AIC:

- Second-generation BCC, building on the strengths of VCT to encourage behavior change (i.e., among HIV-positive clients who are more likely to use condoms)
- Increased IEC for communities, aimed at mobilization and sensitization, prevention, services consumption, and behavior change

The Mission must look at ways to extend geographic coverage for VCT services, especially for conflict-affected areas in the north and west that have a weak service delivery infrastructure for HIV/AIDS prevention and care services. Geographic coverage would be most effectively expanded in consultation with the SO9/DCOF team.

In the areas of mobilization and sensitization, AIC should be encouraged to do more training of other community-based service organizations (notably, Philly Lutaya) and to promote more PHA

involvement. AIC should also have an explicit program/strategy to strengthen the capacity of PHA organizations, as well as other CSOs, schools, and faith-based organizations so they can access grants in a manner consistent with short-term objectives for expanding partnerships to augment the package of services that AIC currently provides. There should be continuing efforts to increase couples counseling.

### *The AIDS Support Organization*

As a long-standing partner to USAID/Uganda, TASO is effectively positioned to provide targeted entry points for service delivery to the community. Given the important role TASO has played in comprehensive care and support and treatment services, the HIV/AIDS Assessment team recommends that USAID/Uganda provide continued support of TASO's care and support portfolio, focusing on the following comprehensive package of services:

- TB services, including TB diagnosis, treatment, tracking/follow-up via Direct Observation Short-Course Therapy (DOTS)
- Clinical care for opportunistic infections
- Care and support for orphans and vulnerable children, including the development of models, guidelines, and practices to inform national policies and support government efforts (as led by the Ministry of Gender and Social Development and other line ministries)
- Home-based care
- Expanded multisectoral linkages for food assistance and nutritional support, in collaboration with the MOAAIF and the P.L. 480 Title II program
- Strengthened referral networks for job placement and income generation, to complement existing vocational skills training.
- Bereavement care
- Grants management/support of other CBOs/CSOs
- Incorporating prevention messages into community-based care and support interventions
- Expanded focus on second-generation BCC
- Training in stigma reduction for public sector health workers based on TASO experience and best practices in providing comprehensive care and support to PHAs and affected families.

TASO's success in expanding service delivery and achieving wider geographic coverage are very much contingent on its capacity for rapid scale-up. TASO will need to balance the goals of rapid scale-up with its internal staffing needs and current capacity to provide services.

### **New Scopes of Work for Integrated Services and Systems Strengthening**

#### ***Services***

Specific point-of-service needs at the district level (public and non-public sectors) are consistent with the HIV/AIDS Basic Package of Services described in the MoH *Health Sector Strategic Plan for 2000/01–2004/5*. This basic package includes:



- IEC/social mobilization
- Surveys, both surveillance and special surveys
- Supply and distribution of condoms
- STI treatment
- Training
- VCT guidelines
- Safe blood practices
- VCT
- Supplies/equipment
- Lab/diagnostic
- Materials
- Texts, guidelines, policy statements, protocols printed, distributed
- Infection control (incinerators, waste material)
- M&E
- Documentation
- PMTCT
- ARVs

Resources should also be targeted to strengthening the capacity for HIV/AIDS prevention and impact mitigation in the education and agricultural sectors, especially life skills training in primary and secondary schools, girls education, and training agricultural extension agents and community-based agricultural and fishery organizations in providing income generation assistance to PLWHAs and vulnerable families.

### ***BCC Needs***

A general outline for a long-term BCC strategy to continue downward trends in reducing seroprevalence among those 15 to 24 years of age is as follows:

- Maintain and expand current IEC/BCC activities among those 15-19 and 20-24-year-olds.
- Continue developing second-stage BCC approaches such as life skills training, and increase interventions and activities through primary and secondary schools, and among out-of-school youth
- Direct more BCC toward older cohorts as well, with emphasis on VCT (particularly couples being tested and counseled together), faithfulness, and condom use.
- Maintain or increase preventive activities for higher risk groups that are currently underserved or undertargeted. These groups might include sex workers, truck drivers, motorcycle taxi drivers, internally displaced persons (IDPs), refugees, out-of-school youth and street children, forest workers, plantation workers, fishermen and -women, and owners and workers in bars, discos, and restaurants. Regionally, the highest HIV infection rates seem to be in Gulu, an area of conflict, IDP camps, among soldiers, and in places with a relative lack of AIDS interventions. Efforts to reach such targets must be done in ways that do not contribute to stigmatization or to the general public believing that AIDS is mostly a problem of special groups.
- Reach underserved districts with improved peer education and community-based training of trainers, and school-based AIDS education and life skills training.

## ***Systems***

To address gaps identified in the enabling environment for HIV/AIDS prevention and impact mitigation, priorities for USAID/Uganda should be centered on:

- Strengthening processes for coordination, participatory planning, information management, and advocacy, specifically focusing on increasing PHA involvement, and establishing systems for transparency and accountability at central, district, and sub-district levels
- Resource mobilization/allocation, ensuring that central and district-level multisectoral HIV/AIDS planning processes are harmonized with central-level budgeting cycles and programmatic disbursements designated for HIV/AIDS in accordance with the PEAP
- Financing, including health insurance, employee welfare programs, and community-based pre-payment schemes for PHAs and affected families
- Monitoring and Evaluation, including establishment of central and district-level monitoring systems for the *National Strategic Framework for HIV/AIDS Activities*, and strengthened capacity of district and sub-district management teams to gauge progress against standard NSF indicators and targets
- Surveillance systems strengthening, including BSS (behavioral sentinel surveillance) and KABP data collection, and increasing the number of VCT sites for surveillance reporting
- Quality assurance/performance improvement, especially building district- and sub-district-level capacity for quality assurance and use of problem-solving approaches to improve the quality and cost-effectiveness of HIV/AIDS prevention, care, and treatment services
- Programmatic interventions to strengthen systems should also build on the achievements of non-facility-based systems services, such as the gains achieved through sensitization of local leaders, community-based initiatives for home-based care, post-test clubs, and food assistance to PHAs, orphans, and vulnerable groups.

## ***HIV/AIDS Integrated Model District Program***

The HIV/AIDS Integrated Model District Program (AIM) project is the mechanism under SO8 most effectively positioned to address gaps in district-level coordination of HIV/AIDS interventions in those districts where AIM will be implemented. In finalizing the district selection process, it will be very important for the SO8 team to look at the capacity that has already been built under AIC, TASO, Strengthening Decentralization in Uganda Project, and Delivery of Improved Services for Health (DISH), and to draw on these activities for models, experiences, and best practices. AIM's functions are to:

- Strengthen the coordination roles of Uganda AIDS Commission and Uganda Network of AIDS Service Organizations
- Support government and coordination of HIV/AIDS prevention, care, and support services at national and district levels
- Build cohesion between public and private sector roles in supporting *National Strategic Framework for HIV/AIDS Activities* goals and objectives.

## **Additional Opportunities: The Private Sector**

The role of the private sector, including commercial farming, plantation, mining, hotel, brewing, and tourist industries, requires more consideration in developing an integrated strategy for HIV/AIDS prevention and impact mitigation. Although small in scale, workplace interventions and the supportive role of the private sector in general are very important. The adoption of African Growth and Opportunity Act and International Labor Office workplace guidelines and learning from best practices developed in other countries in the East and Southern Africa regions (particularly Botswana) would be very relevant for Uganda.

## **Illustrative Examples for Integrating HIV/AIDS Activities into New and Existing Mechanisms under SO7, SO8, and SO9**

The HIV/AIDS Assessment Team proposes the following illustrative activities for integrating HIV/AIDS into Mission-wide strategic approaches (including SO7 Improved Economic Sustainability, SO8 Systems and Services, and SO9 Governance, Democracy and Conflict), with a focus on the HIV/STI sub-results in IRs 8.1, 8.2 and 8.3:

### *Example 1*

#### **SO8**

Priority Intervention Area: *Strengthened Capacities*

Title: Strengthening Systems for Coordination, Planning, and Resource Allocation at National, District, and Sub-district Levels

- Strengthen capacity for planning, coordination, budgeting, grants management, resource allocation, and systems for monitoring and evaluation in keeping with the *National Strategic Framework for HIV/AIDS Activities* and PEAP.
- Strengthen the role of UNASO in working with UAC to promote coordination among civil society organizations and district-level AIDS Focal Committees, and support the development of quality indicators.
- Coordinate with the SDU project in defining selection criteria for the AIM project, and to further streamline HIV/AIDS planning processes in line with the broader local government planning process across sectors.
- Look to the experience and management capacities in those districts where the DISH I and II projects have been working to strengthen the quality and comprehensiveness of care for reproductive health and STI services, and build on best practices and lessons learned. Leverage resources with the EU, NORAD, and DANIDA to assist those districts beyond the 12 districts targeted under AIM.
- Strengthen capacity of community service organizations in BCC and care.

### *Example 2*

SO8, SO7, SO9

Priority Intervention Area: *Strengthened Capacities*

Title: Improving Coordination among USAID Uganda SO Teams

- Develop Multisectoral Response to Food Assistance and Income Generation Support
- Arrange for the collaboration of SO7, SO9, and SO8 teams to strengthen the multisectoral response for food assistance and income generation activities in AIM districts and in those districts served by DCOF (Displaced Children and Orphans Fund) and the SDU project.
- Encourage AIM districts to link with TASO sites in conjunction with the SO9 team to widen service provision in the areas of nutritional support and income generation activities for persons living with HIV/AIDS.
- Look to the experience of microfinance organizations, like FINCA (the Foundation for International Community Assistance) as an entry point for the development of community-based health insurance schemes for PHAs in rural areas; interventions such as these would help PHAs and affected families have a wider range of options for resource mobilization to purchase medications, in addition to having more regular access to comprehensive care and preventive services.
- Encourage the creation of referral linkages between TASO, or other CSOs working at the community level, could establish referral linkages with microfinance organizations to help minimize disparities based on income, place of residence, and sero-status.

### *Example 3*

SO8 and SO9

Priority Intervention Area: *Expanded access to and utilization of HIV/AIDS prevention, care and treatment services*

Title: SO8 and SO9/DCOF Collaboration on the Provision of OVCA Care and Support, STI Treatment, and Condom Social Marketing for Displaced and Conflict-Affected Populations in Border Areas

- Strengthen programmatic linkages between support and assistance to children made vulnerable by conflict and children affected by HIV/AIDS. Criteria that could guide USAID's selection of conflict- and IDP-affected regions as part of the AIM district selection process might be the following:
  - Areas with high-risk populations
  - Areas with populations that are currently concentrated
  - Areas offering a comparative advantage for USAID in that a significant number of USAID activities are being carried out there already
  - Poverty level per capita
  - Limited presence/involvement of civil society organizations
  - School enrollment rates
  - School retention rates.

- Strengthen IEC, STI treatment, and condom social-marketing interventions specifically targeted to the needs of IDPs (particularly female cohorts ages 15-29) to lower the risk of HIV/STI transmission.
- Expand coverage in providing HIV/AIDS/STI services to risk groups residing in border areas, including the military, truckers, and CSWs.
- Establish linkages with community psychosocial support interventions that the SO9 DCOF project is supporting in key districts in the northern and western regions of the country.

#### *Example 4*

S08

Priority Intervention Area: *Second-generation Behavior Change Communication (BCC)*

Title: Collaboration between the Ministry of Education and Sports, TASO and AIC to Promote IEC for In-School and Out-of-School Youth

- Develop second-stage BCC approaches, such as life skills training, and empowerment interventions for girls and boys, targeted through primary and secondary schools, and to out-of school youth, orphans, and vulnerable children and adolescents.

#### *Example 5*

SO8, SO7, and SO9

Priority Intervention Area: *Strengthened capacities*

Title: Better Integrate SO Team Coordination in the USAID/Uganda Mission

- Institutionalize mission-wide coordination mechanisms to ensure that all HIV/AIDS activities undertaken by the SO8, SO7, and SO9 teams are complementary, mutually reinforcing, and coordinated.
- Coordinate USAID mission efforts with HIV/AIDS activities supported by other U.S. Government entities such as CDC, DoD, Peace Corps, and USAID REDSO among others.

#### *Example 6*

S08

Priority Intervention Area: *Improved quality of prevention and care services*

Title: Strengthen Clinical Services Relating to STIs, OIs, and HIV/AIDS

- Build on the DISH project's experience in training health workers, with an emphasis on building capacity for the clinical management of HIV/AIDS, OIs and emerging OIs. Specific interventions include training of health workers in the public and private not-for-profit sectors in both clinical care and stigma reduction, strengthening systems for supplies and commodities management, and expanding geographic coverage to underserved and remote areas.
- Establish systems for quality management and performance improvement in public and private not-for-profit facilities, including development of definitions of quality for HIV/AIDS treatment, care, and preventive services.
- Provide training in the prevention, diagnosis, and management of OIs.

### *Example 7*

S08

Priority Intervention Area: *Promotion of social safety networks for orphans and vulnerable children*

Title: Strengthening Social Safety Nets for Orphans and Vulnerable Children and Adolescents

- Together with the Ministry of Education and Ministry of Gender and Social Development, strengthen resource mobilization and education financing options for payment of school fees, to lower school drop-out rates for orphans and vulnerable children and adolescents.
- In collaboration with the Ministry of Education, support training and peer counseling for teachers at primary and secondary levels on the psychosocial needs of orphans and vulnerable children and adolescents, and more directly help these young people to access a wider range of services for care, support, IEC, and socioeconomic mitigation.
- In collaboration with other donors, leverage support for management strengthening and capacity building in care and support organizations such as TASO or KCCC, to serve as points of entry or referral for IEC, VCT, and STI services for vulnerable adolescents.

### *Example 8*

S08

Priority Intervention Area: *Improved quality of prevention and care services*

Title: Expand PMTCT Under AIM and the Clinical Services Scope of Work

- The Government's decision to scale up PMTCT interventions is one that USAID should fully support. The challenge for USAID is to define its own optimal role to determine how it will work with and support others already implementing PMTCT programs in Uganda. USAID can provide considerable expertise in scaling up counseling, operational research, monitoring and evaluation, community mobilization, safe feeding practices, and maternal/child health services among others. The AIM model district program also provides USAID a unique opportunity to scale up PMTCT activities beyond the existing "pilot" sites.
- USAID should seek to support ongoing PMTCT programs by providing the technical assistance to develop a more comprehensive PMTCT package that also focuses on the mother and family, including the HIV-infected child when transmission is not interrupted.
- USAID should assist the UAC/ACP in finalizing the PMTCT scale-up plan and build into the AIM project the expansion of VCT and the phased development of a comprehensive PMTCT package. Such a package should be based on the Ministry of Health Policy "For the Reduction Of Mother to Child HIV Transmission in Uganda," and the USAID "Practical Guide For MTCT Programs."
- USAID may wish to consider supporting UNICEF, Elizabeth Glazer Pediatric Foundation, and CDC in their efforts to scale up mother-to-child prevention activities in Uganda.

## **V. CONCLUSION**

The HIV/AIDS Assessment Team completed an intensive assignment over a very short-two week period. The findings contained in this report are intended to support the Uganda Mission's broader planning process of designing a comprehensive strategy for HIV/AIDS prevention, treatment, care and support, and build on USAID's successful legacy as a major contributor and partner to Uganda's fight against AIDS.

The team's recommendations are grounded in the importance of building on previous accomplishments in the work of USAID/Uganda as a major supporter of Uganda's national response, and the successes that have been documented to date. The team's recommendations also bear important implications for USAID's continued support of multisectoral responses, and reinforces the importance of working collaboratively across sectors to achieve the greatest impact with available resources.





## **APPENDIX A: Statement of Work**

### **Background**

USAID/Uganda has developed a new Integrated Strategic Plan (ISP) for 2002-2007, which was approved in Washington in June 2001. The ISP supports Uganda's focus on poverty alleviation as articulated in the Government of Uganda's Poverty Eradication Action Plan (PEAP). In this respect, the new goal for USAID/Uganda is to "assist Uganda to reduce mass poverty." This goal directly supports the PEAP's broadest objective, which is to reduce mass poverty to 10% by 2017. Although USAID/Uganda will continue to work in all of the sectors in which it is currently active, the existing strategic framework encompassing six strategic objectives will be replaced by three consolidated Strategic Objectives addressing (1) sustainable opportunities for rural sector growth; (2) improved human capacity (education and health); and (3) more effective and participatory governance. This Scope of Work is intended to address Strategic Objective (SO) 8 (Improved Human Capacity) activities.

Despite Uganda's success in sustaining a high rate of economic growth and reducing poverty over the past decade, these positive economic trends are not reflected in the most recent health and education statistics. Uganda's literacy and primary school enrollment and completion rates are low, particularly for women. Fifteen percent of children die from largely preventable causes before their fifth birthday while immunization rates continue to fall. Fertility rates remain high at 6.9 births per woman, and household size has increased from 4.1 to 5.2 because of high fertility and adult mortality due to HIV/AIDS.

Human capacity in this SO refers to individuals' ability to reduce their vulnerability to poverty and achieve a better quality of life by improving their levels of health and education. This SO directly supports the PEAP objectives of improving the quality of life of the poor and increasing the ability of the poor to raise their incomes. It also supports Administration objectives of improved education and global health improvement. The main results of this SO are:

- Effective use of social sector services (IR 8.1);
- Increased capacity to sustain social sector services (IR 8.2); and
- Strengthened enabling environment for social sector services (IR 8.3).

For the cohort of children 5 years of age and under, this SO will implement integrated education and health interventions to help reduce young child mortality from malaria, vaccine preventable diseases, malnutrition, and HIV/AIDS. For the cohort of children aged 6 to 14, this SO will focus on quality primary education, especially for girls, and HIV/AIDS interventions, especially for orphans and vulnerable children. For the cohort of adults aged 15 and above, this SO will focus on the key problem of high fertility as well as HIV/AIDS prevention, treatment, care and support.

### **Purpose of The Contract**

With the Integrated Strategic Plan (ISP) 2002-2007 approved, the Mission is in the process of designing activities that will achieve SO8's objectives. Technical assistance is needed for the technical sections of contractible statements of work or program descriptions. Approximately

five such documents are anticipated (one of them specific to HIV/AIDS). The contractor will provide the required technical staff for the HIV/AIDS design team, which will serve as a member of the larger design team. The large team will, in coordination with mission support offices (CO, EXO, FMO and PDO) and the SO8 team, produce these technical documents.

## **Statement of Work**

In producing the deliverables, the design assistance team will provide technical assistance to:

Identify priority HIV/STI/OI sub-results for advancing the Mission's (SO8 and other SOs) and contributing to the PEAP objectives.

Conduct a desk review of the national strategic framework (NSF) and current and planned nation-wide response to address the NSF.

Identify institutional gaps in the nation-wide response to the HIV/AIDS epidemic in Uganda. (Apparently there is a meeting scheduled for 11/23/01 with the Uganda AIDS Commission and others to discern just that.)

Identify which gaps will be addressed through USAID/Uganda's new and existing instruments (AIM (AIDS/HIV Integrated Model District Program; Systems contract; Services cooperative agreement; AIC and TASO, other SO instruments).

Propose recommendations for addressing gaps, over the next 6 years, that are in keeping with SO8's priority HIV/AIDS sub IRs that can be addressed by expanding existing mechanisms or require new interventions.

Work with the SO8 team to identify illustrative activities that will integrate HIV/AIDS into Mission wide strategic approaches (including SO8 Systems and Services, SO7 Improved Economic Sustainability, SO9 Governance, Democracy and Conflict), with a focus on the HIV/STI sub-results in IRs 8.1, 8.2 and 8.3. A special focus will be on integrating HIV/AIDS into education.

## **Suggested Approach**

The HIV/AIDS activity design team will visit Uganda between November 26 and December 7, 2001. To achieve the deliverables, the team will:

Review pertinent documents, including but not limited to the USAID/Uganda Integrated Strategic Plan 2002-2007, R4 reports, relevant GOU and civil society documents including the PEAP and Vision 2025, the Health Sector Strategic Plan, SO8 strategic implementation plans, situation analyses, sector assessments, evaluations, and HIV/AIDS specific documents.

Meet/hold discussions with key personnel including the USAID/Uganda Mission Director, SO team members and leaders, Program Office, key Embassy officials, implementing partners (contractors, PVOs/NGOs, GOU counterparts), key civil society organizations, other donors, the Ministry of Health, the Ministry of Education and Sports, and local officials.

Conduct field visits, as needed, to present and prospective activity sites including areas affected by conflict. (time dependent)

Collaborate and coordinate with other SO8 design team members to ensure integration of HIV/AIDS into all SO8 deliverables.

Collaborate and coordinate with other Mission SO teams to ensure integration of HIV/AIDS in all Mission activities as appropriate and feasible.

As time permits, work with larger design team to develop SO8 deliverables (not just integration of HIV/AIDS) as relates to HIV/AIDS design team skill base e.g., decentralization, multisectoral, BCC, etc.

## **Deliverables**

A technical document for HIV/AIDS activities, following an outline to be agreed upon prior to the field visits. This document will include: a summary of nation-wide gaps in the response to HIV/AIDS; priority HIV/STI/OI sub-results; illustrative examples for integrating HIV/AIDS into existing mechanisms; description of gaps that will be addressed through Mission instruments; recommendations for addressing gaps not met through new or existing mechanisms.

SO8 deliverables that have HIV/AIDS-integrated strategies.

Debrief key Mission staff.

A concise summary elaborating on the process used to develop the report. The summary should give the mission a sense of the collaborative process involved, including interactions with non-USAID partners and stakeholders.

The design assistance team will deliver the final HIV/AIDS technical document (hard copy and electronic copy) to the SO8 Team Leader in a form, consistent within the agreed outline, and with content satisfactory to the Teams.

## **HIV/AIDS Design Team Composition**

*Multisectoral specialist:* The multisectoral specialist will contribute to the development of a Mission activity plan aligned with Expanded Response goals and targets; the NACP strategic plan, the GOU's broad-range strategy for poverty reduction, and national-level priorities for decentralization in the context of strengthening district-level systems for the planning, delivery and monitoring of HIV prevention and care services. The multisectoral specialist would also identify how HIV/AIDS interventions make a distinct and measurable contribution to the SO8 result, "*Improved Human Capacity*," through an emphasis on the identification of appropriate multisectoral linkages for existing Mission activities currently in progress, and recommendations for new activities which may be integral to SO8 results and sub-results focusing on improved social services; a strengthened policy environment heightened by community participation, PLWA-involvement, private-sector representation, and local government capacity-building.

*Behavior change communication specialist:* This consultant will provide the focus on behavior change and communication activities in the activity design and identify programmatic linkages with other important components in the health, education, and social sectors.

*Data collection/reporting system specialist:* This team member will review the current reporting system between USAID implementing agencies and the Mission. She will review current Mission reporting requirements and procedures and clarify their relationship to the SO8 HIV/STI/OI sub-results. She will facilitate discussion of Mission aims and needs with regard to gathering, analyzing and reporting on HIV/AIDS results to Ugandan partners, Mission managers, and USAID/Washington in order to inform the design of the Expanded Response program information database.

*Clinical services specialist:* The consultant will review the activities in place for delivering clinical HIV/STI/OI services, including the capabilities of USAID's implementing partners. He/she will propose, in consultation with the HIV/AIDS activity design team, priority clinical services required to meet the HIV/AIDS sub-results and Expanded Response goals and targets. He/she will also make recommendations on the appropriate targeting and coverage goals of the recommended activities as well as recommendations on the effective integration of these activities into the existing mechanisms. Furthermore, he/she will provide insight and recommendations regarding promising linkages with other sectors and SOs.

*Community-based care and support specialist:* The consultant will play a critical role in bridging the PEAP objectives, the SO8 Intermediate Results, and the HIV/AIDS sub-results. He/she will examine existing activities and identify patterns of referral and community-based prevention, care and support activities. He/she will identify the capabilities of USAID's implementing partners in delivering community-based services. He/she will consult with representatives of community NGOs and PLWHA networks relevant to achieving SO8. He/she will make recommendations on clinical, community-based, policy and government services critical to achieving the PEAP objectives of improving the quality of life of the poor and increasing the ability of the poor to raise their incomes.

*Monitoring and evaluation and surveillance specialist/resource person:* This part-time team member/resource person from the MoH will provide the team with available information on the national AIDS program's monitoring and evaluation framework, indicators, and targets and on relevant GOU, NGO and other data sources and data collection systems. He/she will assist the team with evidence-based decision-making regarding recommended targeting and coverage of HIV/STI/OI services planned under SO8. He/she will also act as the principal liaison with the GOU partners.

### **Level of Effort**

The team will spend 66 person-days dedicated to the AIDS/HIV design activity.

A six-day work week is authorized.

## **APPENDIX B: Study Methodology**

The HIV/AIDS Design Team conducted a detailed document review to arrive at its findings (see this report's bibliography). In addition, the team held face-to-face interviews with representatives of HIV/AIDS organizations, ministries, donors, and the three main organizations through which USAID carries out its work—TASO, AIC, and AIM. Meetings and discussions were also held with various SO (Strategic Objective) team representatives from SO7, SO8 and SO9. The study team itself held numerous meetings to review its findings. The list of people interviewed is found in Appendix C.

The following questions guided the team in obtaining information:

### **Expanded Response**

- What systems are still needed to improve access, efficiency, and quality of HIV/AIDS services in Uganda, at the national, district, and sub-district levels? What is the capacity for rapid scale-up?
- What do you see as the critical elements that need to be in place to expand coverage? Where are the gaps?

### **Youth**

- What interventions have been designed specifically to reduce seroprevalence among youth? What has worked and why? What are the gaps?
- What types of assistance have worked to enhance access to education, care and psychosocial support, life skills training, job training, employment, and income generation for vulnerable youth, whether affected by HIV/AIDS or not?

### **Multisectoral Response**

- What has been the multisectoral response to HIV/AIDS in Uganda?
- What sectors have been mobilized?
- What resources have been allocated for HIV/AIDS in these sectors?
- What multisectoral linkages need to be strengthened to mitigate the impact of HIV/AIDS on orphans, vulnerable children and adolescents, and other youth?
- What MSR links can be established to improve PMTCT, VCT, and STI services?
- How well are systems working to support the coordination of services?
- What do the different donors bring, and is there any overlap? Are there any areas that have received under-attention?

### **PHA Involvement**

- How have PHAs been involved in advocacy and policy formulation?
- What are the gaps relating to PHA involvement?

- What kinds of programmatic interventions are still needed to increase PHA involvement in planning and policy formulation?
- What do you consider to be the role of support groups in the fight against AIDS, and how have PHA networks contributed?

### **Behavior Change Communication**

- Has there been sexual behavior change (SBC) in recent years?
- Which behaviors have changed the most and the least?
- What have been the causes of this SBC?
- What have been the constraints to SBC?
- Has SBC been sustained? That is, are the changes continuing, slowing, reversing, or changing direction?
- Have the behavioral gains among youth been sustained?
- What are the challenges for BCC with older age cohorts?
- Which age groups have changed the most, and the least? Are there gender differences in the degree or type of SBC?
- What interventions have been designed to promote behavior change among youth? What has worked and why? What still needs to be done to delay age of sexual debut, particularly among girls?
- What has been the role, if any, of schools in promoting or motivating SBC?
- What has been the contribution of mass media, print media, and interpersonal (face-to-face) IEC in motivating SBC?
- What recent studies provide data on any of the foregoing, and where can they be obtained?
- What is the Government of Uganda's current strategy for IEC?
- What are the target groups?
- What else is needed to strengthen the prevention focus, now that gains have been made in reducing prevalence in Uganda?
- What is being done to raise awareness?
- What are the strategies for prevention of STIs, opportunistic infections, and mother-to-child transmission of HIV/AIDS?

### **Monitoring**

- How frequently are data collected?
- In what manner?
- How are data stored/processed (e.g., database)?
- How are data verified (e.g., site visits, review of records)?
- What are the data used for?
- What kind of data/information are collected routinely?
- Are quality indicators used?
- Are special studies and evaluations carried out?

## **Clinical Services**

- What is the mission of your organization?
- What are ongoing interventions, and their strengths and weaknesses?
- What do you think needs to be done to maximize the effectiveness of your interventions?
- Do you have any other interventions you may consider feasible and effective?
- What is the difference between the availability and quality of services in the public sector vs. the private sector?
- How are services organized for STIs, TB, other opportunistic infections, and syphilis?
- Do you have any TB activities? What are they?
- What is your capacity for screening, diagnosis, treatment, prevention therapy, follow-up and referrals to the National TB Program?

## **Please List**

- Desired outcomes
- Services and activities
- Capacity to deliver services
- Expansion plans
- Quality of services
- Ability to take on new interventions
- Source of resources
- Gaps

## **Delivery Systems**

- What are the gaps in services provided, in prevention, care and support, and mitigation of the impact of HIV/AIDS?
- What would you consider to be contributing factors to Uganda's success story?
- Given resources, where would you concentrate your efforts?
- What do you have to say about VTC delivery in Uganda regarding effectiveness, efficiency, and coverage?

## **Issues**

- Feelings about services delivery
- Gaps in delivery of services
- Way forward

## **OVCA**

- What OVCA programs have there been to date?
- What has worked well and why?
- What gaps still remain?

- Given the stage of the epidemic, what response would be effective and appropriate as a way to maintain downward trends in incidence and prevalence among youth?



## **APPENDIX C: Organizations/Persons Contacted**

### **Agricultural Development Cooperative Initiative/Volunteers in Overseas Cooperative**

Assistance, Title II Project

Scott McNiven, M&E Officer and Deputy Program Manager

### **AIDS Communication Education Training (ACET)**

Paulo Kato, Program Manager

Daudi Talima, Training Manager

Paul Kabunga, Program Manager

### **AIDS Information Centre (AIC)**

Josephine Kalule, Program Manager

Jane Bate

Dr. Hitimana

Dr. Mugisha Baramu

### **Centers for Disease Control and Prevention (CDC)**

Dr. Becky Bunnell, Epidemiologist, CDC/Uganda

Dr. Donna Kabatesi, Program Manager, CDC/Uganda

Ray Ransom, Statistics, Statistics and Data Management Branch (SDMB), Division of Sexually Transmitted Disease Prevention (DSTDP), National Center for HIV/AIDS, STI, and TB Prevention, CDC/Atlanta

### **Church of Uganda**

Reverend Sam Ruteikara, HIV/AIDS Coordinator

### **Commercial Market Strategies**

Elizabeth Gardiner, Social Marketing Director

Peter Cowley, Country Director

### **Creative Basic Research**

Tom Barton

### **Mukono District STI/AIDS Control Programme**

Dr. Tumushabe, HIV/AIDS Focal Person

Dr. S. Wandera, TB Supervisor and Health Education

Representatives of the Multisectoral District HIV/AIDS Team, Mukono District

### **DfID**

Ros Cooper, Health Adviser

James Thornberry, Assistant Health & Population Manager

**European Union -EDF Health Programme**

Wolfram Brunger, Technical Adviser

Islamic Medical Association of Uganda (IMAU)

Dr. Karama, Deputy Chairman

**Kamwokya Christian Caring Community (KCCC)**

Mbazira Francis, Director

Peter Byansi, Program Coordinator, Youth and Street Children Forum

Clare Iga, Clinic Head Nurse

**Mildmay Center International**

Dr. Stephen Ochieng, Trainer and Public Relations Coordinator

**Ministry of Agriculture, Animal Industries, and Fisheries (MOAAIF)**

Mrs. Dinah Kasangaki, HIV/AIDS Focal Person

**Ministry of Education and Sports**

Emmanuel Araali Kusemererwa, Senior Education Officer for Pre-Primary Education and  
National DARE Coordinator

**Ministry of Gender and Social Development**

Edward Mugyimba, Assistant Commissioner and Focal Point Person for HIV/AIDS

**Ministry of Health**

Paul Kagwa, Assistant Commissioner for Education

Dr. Saul H. M. Onyango, Coordinator, PMTCT Programme, STD/AIDS Control Programme

Dr. Joshua Musinguzi, STD/AIDS Control Programme

Dr. Wilford Kirungi, STD/AIDS Control Programme

Dr. Alex Opio, Ministry of Health, STD/AIDS Control Programme

Dr. Elizabeth Madraa, STD/AIDS Control Programme

**National Community of Women Living with HIV/AIDS (NACWOLA)**

Dorothy Namutamba, Coordinator

Jacklilne Nabwire

Betty Ajambo

Jacinta Magero

Rebecca Nakabazi

**Straight Talk Foundation**

Catherine Watson, Director

**The AIDS Support Organisation (TASO)**

Betty Nabirye, Centre Manager, TASO, Mulago Branch

Dr. Alex Coutinho, Executive Director, TASO Uganda Ltd.

Robert Ochai, Head of M&E, TASO Uganda Ltd.

Hannington Nkayivu, TASO Uganda Ltd.

**Traditional and Modern Healers Together Against AIDS (THETA)**

Moses Kipanda

**Uganda AIDS Commission (UAC)**

Professor John Rwomushana, Director, AIDS Research & Policy Development

**Uganda Catholic Secretariat, Nsambya**

Ronald Kamara, HIV/AIDS Focal Person

**UNICEF (United Nations Children's Fund)**

Dr. Mbulawa Mugabe, Programme Officer, HIV/AIDS (PMTCT)

**USAID/Uganda**

Angela F. Lord, SO8 Results Team Leader

Elise Ayers, HIV/AIDS Technical Advisor

Suzanne McQueen, Population, Health and Nutrition Officer

Andrew Paul Kyambadde, Development Assistance Specialist

Ron Stryker, SO7 Results Team Leader

Randy Harris, SO9 Team, Conflict Resolution and D&G

Don Elliott, SO9 Team, Conflict Resolution and D&G

Dan Ahimbisibwe Wamanya, HIV/AIDS Team, SO8



## REFERENCES AND LITERATURE REVIEWED

AIC (AIDS Information Centre). The AIDS/HIV Integrated Model District Programme (AIM): Briefing Sheet.

AIC. AIDS Information Centre (AIC): Information Pack. Print World Investments, Ltd. Uganda.

AIC. AIDS Information Centre (AIC): Life Amendment.

AIC. AIDS Information Centre (AIC): Progress Report for the Period April-June 2001. Kampala, Uganda.

AIM (AIDS/HIV Integrated Model District Programme). 2001. SCOPE. The AIDS/HIV Integrated Model District Programme. Issue 1, Oct.

Alwano-Edyegu, M. G., and E. Marum. 1999. Knowledge is Power: Voluntary HIV Counseling and Testing in Uganda. Geneva: UNAIDS. June.

AMREF (the African Medical and Research Foundation)/Uganda. 2001. The Effects of the Katakwi/ Soroti School Health and Aids Prevention Project. Kampala, Uganda. Aug.

Asiimwe-Okiror, G., A. A. Opio, J. Musinguzi, E. Madraa, G. Tembo, and M. Carael. 1997. Change in sexual behaviour and decline in HIV infection among young pregnant women in urban Uganda. *AIDS* 11(14):1757-63 (Nov. 15).

Barton, Tom. 1997. Epidemics and Behaviours: A Review of Changes in Ugandan Sexual Behaviour in the Early 1990s. Geneva: UNAIDS. Jan.

Bramucci, Gina L. 2001. Unearthed Grace: Stories from Northern Uganda. International Service Volunteers' Association (AVSI). Kampala: Fountain Publishers Ltd.

Dadian, Margaret, ed. 2001. Horizons Report: Operations Research in HIV/AIDS. Horizons Project. Washington, DC: Population Council. Spring.

Gardner, R., R. D. Blackburn, and U. D. Upadhyay. 1999. Closing the Condom Gap. Population Reports, Series H. Johns Hopkins University. April.

Green, E. C. 1998. Report on the Situation of AIDS and the Role of IEC in Uganda. STI Project, World Bank. Entebbe, Uganda: Ministry of Health. Dec. 12.

Green, E. C. 1999. Indigenous Theories of Contagious Disease. Walnut Creek, CA: Altamira Press/London: Sage Press.

Green, E. C. 2000. Calling on the religious community: Faith-based initiatives to help combat the HIV/AIDS pandemic. *Global AIDSLINK* (publication of the Global Health Council) 58:4-5. Jan.

Green, E. C. 2001. The contribution of faith-based organizations to HIV/AIDS prevention: Evidence from Uganda and Jamaica. Paper presented at the conference Challenges for the Church: AIDS, Malaria & TB. Arlington, VA: Christian Connections for International Health. May 25-26.

Green, E. C. (Expected late 2002 or 2003.) The AIDS Crisis in Poor Countries: the Need for Bold, New Approaches to Prevention. Westport, CT: Auburn House, Greenwood Publishers.

Green, E. C., and Aldo Conde. 2000. Sexual partner reduction and HIV infection. Sexually Transmitted Infections 76(2):145.

Government of Uganda, Uganda AIDS Commission, Joint United Nations Programme on AIDS, Other Stakeholders in HIV/AIDS. 2000. National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1- 2005/6.

2001. HIV/AIDS Surveillance Report. June.

Ireland Aid/Embassy of Ireland, Ministry of Health (Uganda), National Community of Women Living with HIV/AIDS (NACWOLA), and The AIDS Support Organisation (TASO). HIV/AIDS in Uganda (brochure).

Kagimu, M., E. Marum, F. Wabwire-Mangen, N. Nakyanjo, Y. Walakira, and J. Hogle. 1998. Evaluation of the effectiveness of AIDS health education interventions in the Muslim community in Uganda. AIDS Educ Prev. 10(3):215-28 (June).

Kaleeba, N., J. Namulondo, D. Kalinki, and G. Williams. 2000. Open Secret: People Facing Up to HIV and AIDS in Uganda. Strategies for Hope Series, no. 15. London: ActionAIDS.

Low-Beer, D., R. Stoneburner, T. Barnett, and M. Whiteside. 2000. Knowledge diffusion and personalising risk: Key indicators of behaviour change in Uganda compared to South Africa. XIII International Conference on AIDS, Durban, South Africa, July 7-14. ThPeD5.

Marum, E., and E. Madraa. 2000. The Role of Donors in Empowering an Effective National Response to AIDS: The Uganda Example. Power Point Presentation. XIII International Conference on AIDS, Durban, South Africa, July 7-14.

Mildmay International. Mildmay International Portfolio. London.

Mildmay International. Mildmay International Welcomes You to Jajja's Home: A Children's Day Care and Rehabilitation Centre (brochure). Kampala, Uganda.

Mildmay International. Specialist care and training in HIV/AIDS at the Mildmay Centre Uganda.

Ministry of Agriculture, Animal Husbandry and Fisheries, Agricultural Sector Response to the HIV/AIDS Epidemic. 2000.

Ministry of Agriculture, Animal Husbandry and Fisheries. 1997. Feeding Guidelines for People Living with HIV/AIDS: A Handbook for Field Extension Workers. Ministry of Agriculture, Animal Husbandry and Fisheries, The Republic of Uganda and UNDP. Entebbe, Uganda. Oct.

Ministry of Agriculture, Animal Husbandry and Fisheries. Nutrition and HIV/AIDS: A Handbook for Field Extension Agents. Ministry of Agriculture, Animal Husbandry and Fisheries, The Republic of Uganda and UNDP. Entebbe, Uganda.

Ministry of Education and Sports. 1998. Education Strategic Investment Plan 1998-2003. Ministry of Education and Sports, The Republic of Uganda. Nov.

Ministry of Education and Sports. 2001. Sixth Education Sector Review: Final Aide Memoire. Ministry of Education and Sports, The Republic of Uganda. Oct.

Ministry of Finance, Planning and Economic Development. 2001. Poverty Eradication Action Plan (PEAP): Building Partnerships to Implement PEAP. Final draft. Ministry of Finance, Planning and Economic Development. Kampala, Uganda. May.

Ministry of Health (MoH), Government of Uganda. 2000, 2001. Unpublished reports, tables, raw data from population surveys. STD/AIDS Control Programme.

Ministry of Health (MoH). Health Sector Strategic Plan 2000/1–2004/5. Ministry of Health, The Republic of Uganda.

Ministry of Health (MoH). 2001. Policy for the Reduction of Mother-to-Child HIV Transmission in Uganda. Ministry of Health, The Republic of Uganda. July.

Moodie, Rob, A. Katahoire, F. Kaharuzza, D. O. Balikowa, J. Busuulwa, and Tom Barton. 1991. An Evaluation Study of Uganda AIDS Control Programme's Information, Education and Communication Activities. Uganda Ministry of Health AIDS Control Programme, Uganda and WHO, Global Programme on AIDS. July-Dec.

Mukono District Council. Draft Paper of the Multi-Sectoral HIV/AIDS Workplan 2001/2002. Mukono District Council, Uganda.

NACWOLA (National Community for Women Living with HIV/AIDS). 1999. Child Link: The Children's Newsletter. Kampala, Uganda.

NACWOLA. 1999. National Community of Women Living with HIV/AIDS in Uganda (NACWOLA): Fact Sheet (brochure). Kampala, Uganda.

NACWOLA. 2001. Positive Woman: A Newsletter of the National Community of Women Living with HIV/AIDS (NACWOLA). Vol. 7, issue 2 (Oct.).

NADIC (National AIDS Documentation & Information Centre). 1998. NADIC Bulletin, issue 2 (Dec). Uganda AIDS Commission. Kampala, Uganda.

2001. National HIV/AIDS Comprehensive Communications Strategy: Concept Paper. July.

The National Strategic Framework for HIV/AIDS in Uganda: 2000/1–2005/6.

Okware, S., A. Opio, J. Musinguzi, and P. Waibale. In press. Fighting HIV/AIDS: Is success possible? Bulletin of the World Health Organization.

Orphans and Vulnerable Children: Terms of Reference.

Painter, Thomas M. 2001. Voluntary counseling and testing for couples: A high-leverage intervention for HIV/AIDS prevention in sub-Saharan Africa. *Social Science & Medicine* 53(11):1397-1411 (Dec.).

The Republic of Uganda. 2001. Joint Review Mission of Government of Uganda and Development Partners in the Health Sector: Aide Memoire. Kampala, Uganda: The Republic of Uganda. Oct.

The Republic of Uganda. Life Skills for You (brochure). The Republic of Uganda and United Nations Children's Fund (UNICEF).

Schietinger, Helen, and Linda Sanei. 1998. Discussion Papers on HIV/AIDS Care and Support: Systems for Delivering HIV/AIDS Care and Support. Discussion Paper Number 8. (Reprinted June 2000.)

Sentumbwe, and Nakkazi. 1998. [need title] International Conference on AIDS. 12:918 (abstract no. 43365).

Shelton, James D., and Beverly Johnston. 2001. Condom gap in Africa: Evidence from donor agencies and key informants. *BMJ* 323:139 (July 21).

Shuey, D. A., B. B. Babishangire, S. Omiat, and H. Bagarukayo. 1999. Increased sexual abstinence among in-school adolescents as a result of school health education in Soroti district, Uganda. *Health Educ. Res.* 14(3):411-9 (Jun.).

Sittirai, Werasit. 2001. HIV Prevention Needs and Success: A Tale of Three Countries. Geneva: UNAIDS.

Stoneburner, R., and M. Carballo. 1997. An Assessment of Emerging Patterns of HIV Incidence in Uganda and Other East African Countries. Arlington, VA: Family Health International/AIDSCAP/ Geneva: International Centre for Migration and Health.

Stoneburner, R., and D. Low-Beer. 2000. Is condom use or decrease in sexual partners behind HIV declines in Uganda? Paper presented at the XIII International AIDS Conference, Durban, South Africa.

Stoneburner, R. L., G. Asiimwe-Okiror, J. Musinguzi, A. Opio, B. Biryahwaho, C. Byabamazima, and P. Turyaguma. 1996. Decline in HIV prevalence in Ugandan pregnant women and its relationship to HIV incidence and risk reduction. *Int Conf AIDS*. Jul 7-12;11 (Program Supplement):16 (abstract no. Mo.C.905).

TASO (The AIDS Support Organisation). TASO 2001 Budget Narrative.



TASO. 2001. Attachment D1(B)—Life Proposal. TASO Mulago Centre Newsletter, vol. 1 (Aug.).

TASO. 2001. TASO Uganda Ltd. (brochure).

Uganda AIDS Commission. 2001. Report on the Coordination Planning Workshop of the Expanded National Response to HIV/AIDS in Uganda at the District Level. Oct.

Uganda AIDS Commission. 2001. Uganda AIDS Commission Review: Final Report. Sept.

UNAIDS (Joint United Nations Programme on HIV/AIDS). 2000. Uganda: Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Diseases. Geneva.

UNASO (Uganda Network of AIDS Service Organizations). 2001. UNASO Best Practices, vol. 1, issue 1 (Sept.). Kampala, Uganda.

UNASO. 2001. UNASO News: The Newsletter of Uganda Network of AIDS Service Organisations, vol. 3, issue 2 (July-Sept.). Kampala, Uganda.

USAID (United States Agency for International Development). 2001. Strengthening Decentralization in Uganda: First Year Work Plan Activities of the United States Agency for International Development Project. Implemented by Management Systems International and Research Triangle Institute. Nov.

USAID/Uganda. AIDS Information Centre (AIC): Cooperative Agreement No. 623-A-00-96-00007-07.

USAID/Uganda. 2001. HIV/AIDS in Uganda and USAID/Uganda's Response: An Overview. Power Point presentation. November 2001.

USAID/Uganda. 2001. Integrated Strategic Plan.

USAID/Uganda. 2001. Performance Monitoring Plan: SO8 and Key Intermediate Results. Nov.

USAID/Uganda. 2000. Request for Applications (RFA) No. 617-01-A-002, Uganda Model District Program. Dec. 2000-Jan. 2001.

USAID/Uganda. USAID/Uganda's HIV/AIDS Program 2001-2007: Draft Concept Paper.

USAID/Washington. 2001. USAID's Expanded Response to the Global HIV/AIDS Pandemic, Tuberculosis, and Malaria. Draft. Nov..

Williams, Glen, Caroline Aloyo Obonyo, Jeannie Annan. 2001. Resilience in Conflict: A Community-based Approach to Psycho-Social Support in Northern Uganda. International Service Volunteers' Association (AVSI) and United Nations Children's Fund (UNICEF). Kampala, Uganda. June.

World Bank. 1999. Uganda: the Sexually Transmitted Infections Project. Findings. World Bank, no. 127. Jan.

Wotti, Richard Wamimbi. Strategies adopted by NGOs in assisting children orphaned by HIV/AIDS: a study of selected NGOs in Uganda. A presentation at the XII International Conference on AIDS/STD in Africa. Ouagadougou, Burkina Faso.